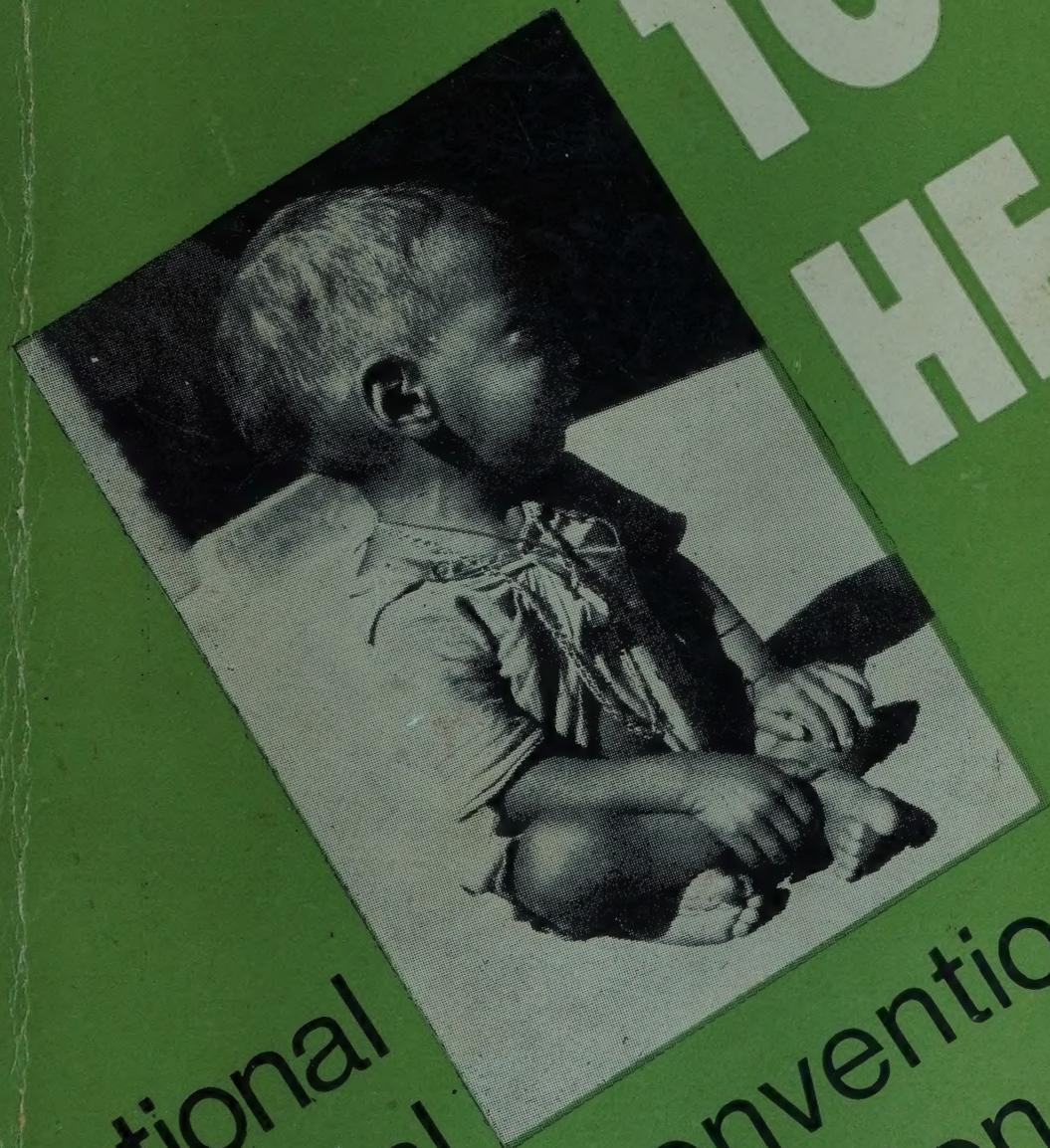


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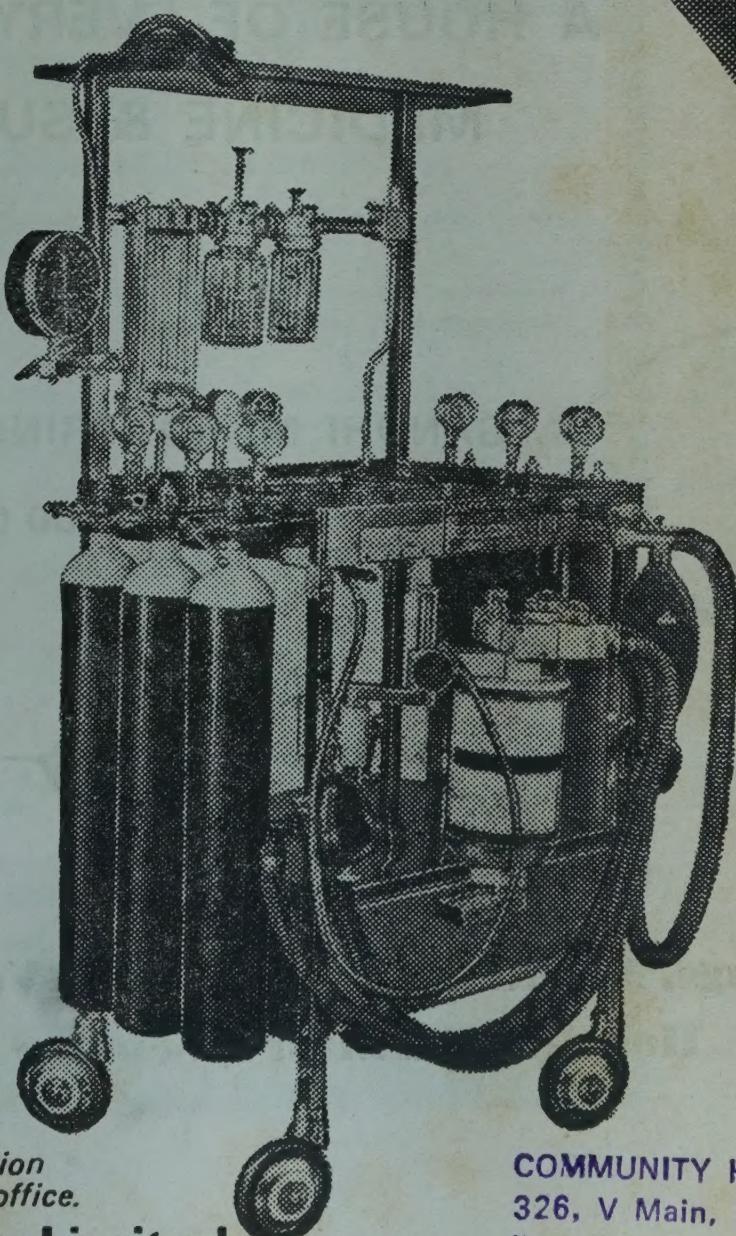
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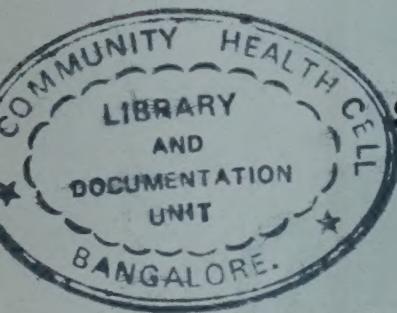
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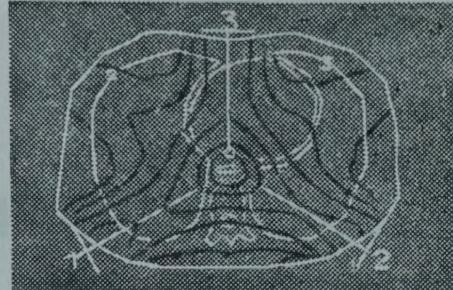
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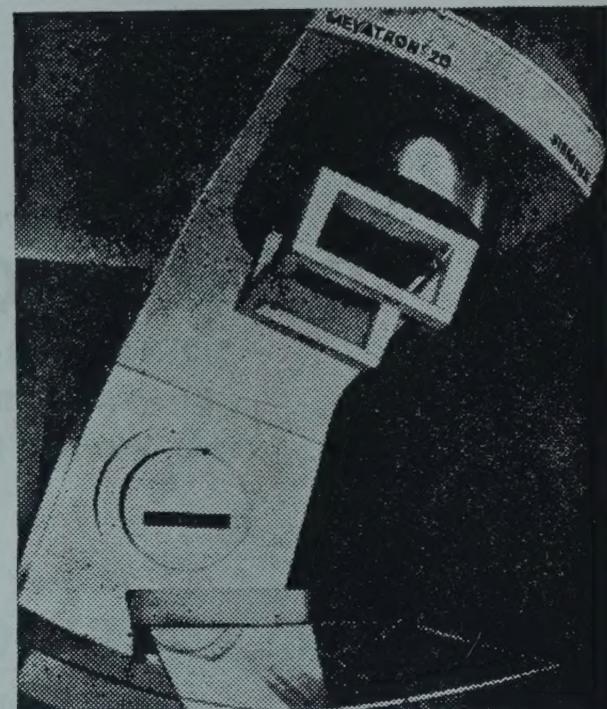
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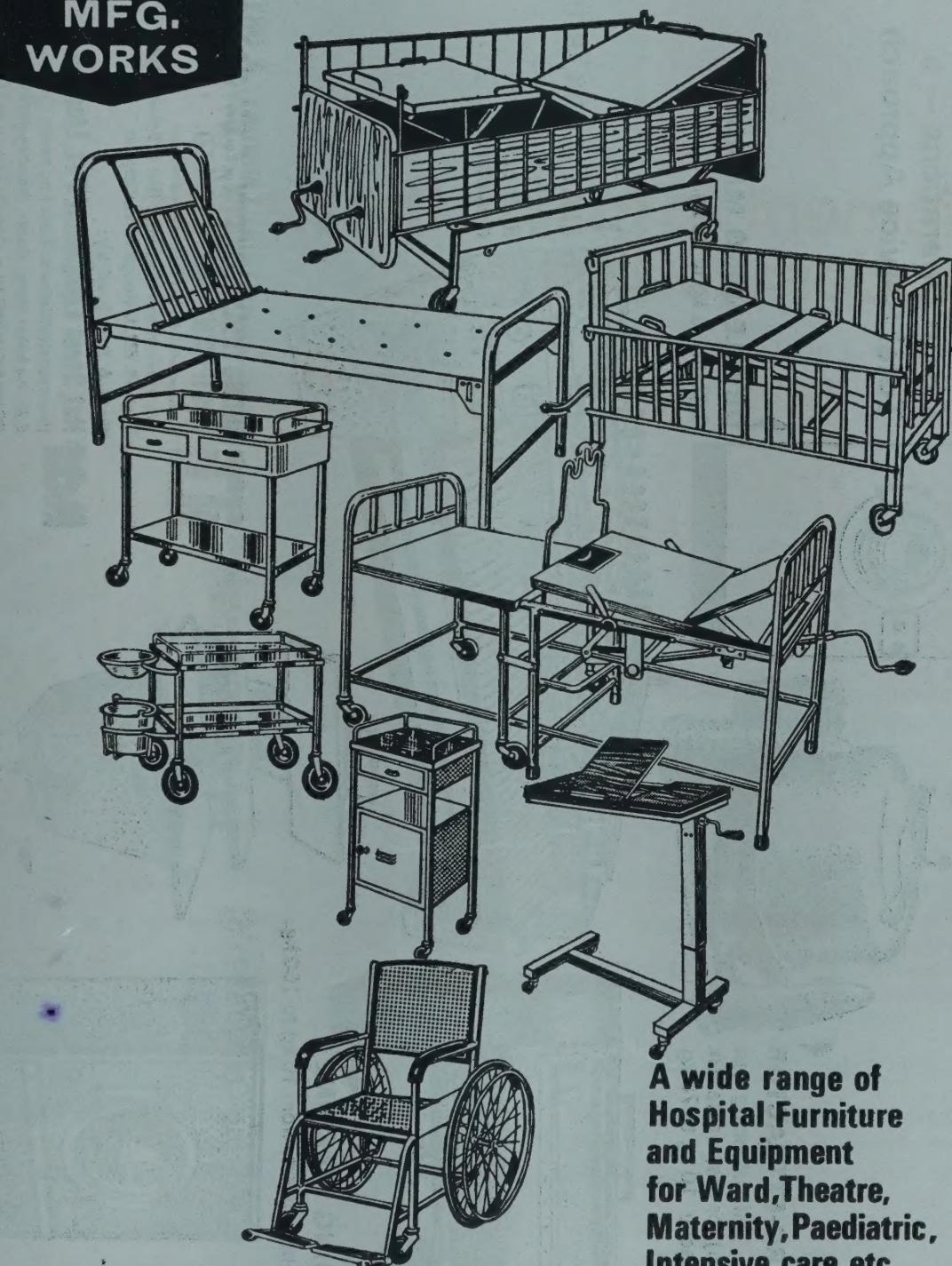
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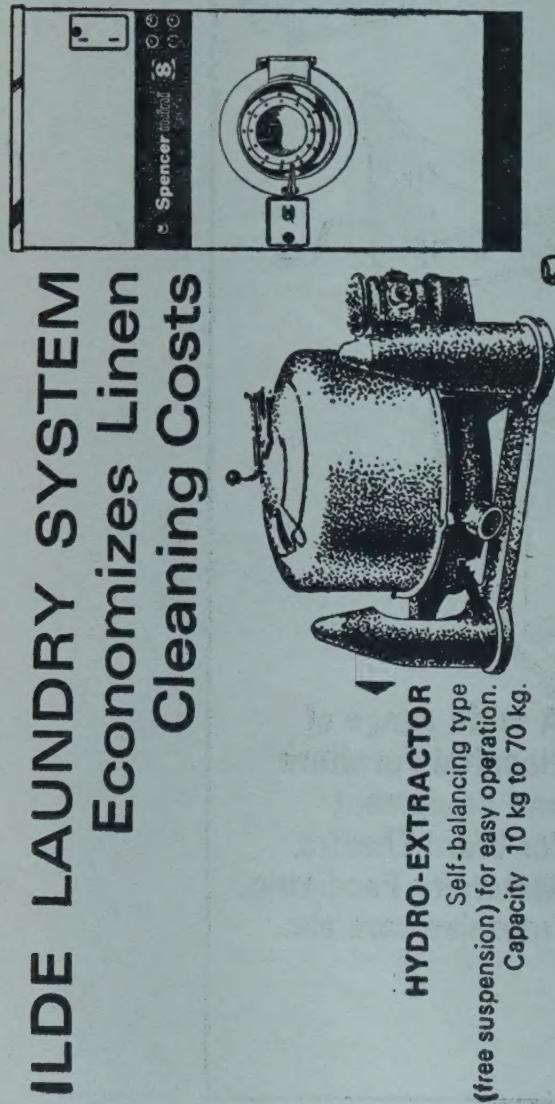
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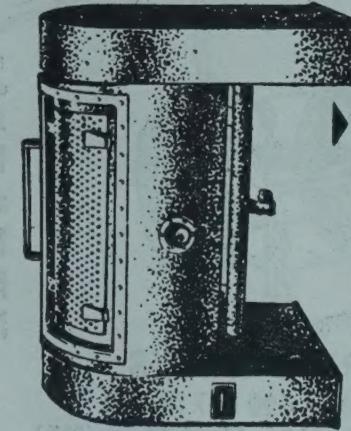


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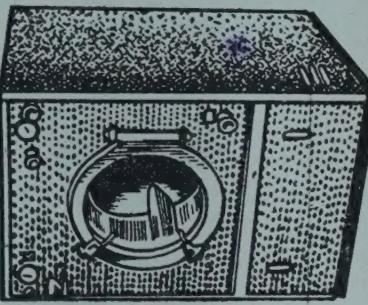
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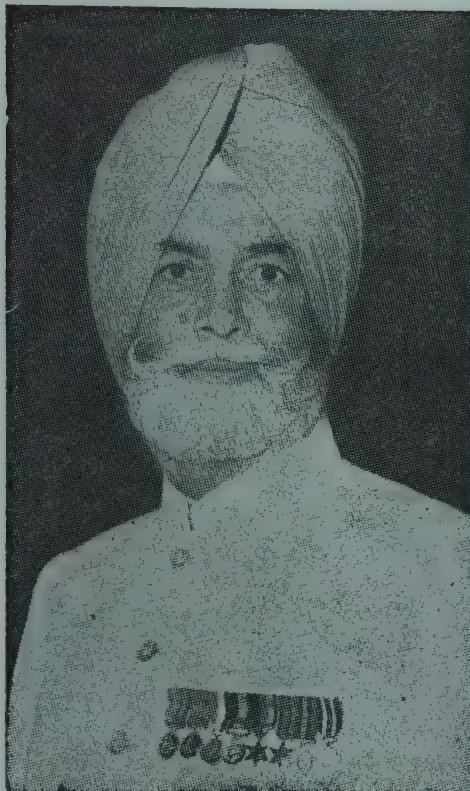
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November 15, 1980

MESSAGE

It is heartening to know that the Catholic Hospital Association of India with its Head Quarters in New Delhi is holding its 37th Annual National Hospital Convention and Exhibition in Old Goa.

The Christian Missionaries have been doing commendable work in the fields of education and health service — specially in rendering medical aid to the poor in remote places. I hope the missionary spirit of brotherly love for fellow beings will guide the members of the Catholic Hospital Association to carry on the noble work of rendering aid and succour to our less fortunate brethren for many years to come.

I wish the Convention and the Exhibition every success.

Sd/-
(Col. P.S. Gill)
Lieutenant Governor

The Executive Director,
The Catholic Hospital Association of India,
C.B.C.I. Centre,
Ashok Place
New Delhi-110001.



CHIEF MINISTER
GOA, DAMAN AND DIU

SECRETARIAT
PANAJI

Dated : 24-10-1980



MESSAGE

I am indeed happy to learn that the Catholic Hospital Association of India, will hold its 37th National Convention and Exhibition at the Pastoral Institute, Old Goa, from November 28th to December 1st 1980.

I deeply appreciate the aims and objectives of the Catholic Hospitals Association which is fulfilling a noble and necessary mission by providing medical treatment facilities to poor and needy patients irrespective of any other considerations except the relief of their sufferings.

I, therefore, extend a cordial welcome to the organisers and participants of the 37th Convention—cum—Exhibition— the first ever to be held in Goa—and wish all success to the programme.

Sd/-

(Pratapsingh Rane)

GOVERNMENT OF GOA, DAMAN AND DIU
SHAIKH HASSAN HAROON
Minister



Minister for Health, Revenue,
Inland Waterways and Town and
Country Planning
Secretariat, Panaji.

Date : November 10, 1980

MESSAGE

I am glad to know that the Catholic Hospital Association of India with its Head Quarters at New Delhi is organising its 37th Annual National Hospital Convention and Exhibition at the Pastoral Institute, Old Goa from November 28 to December 1st, 1980. The theme chosen for this years convention is 'Right to Health' and it is for the first time that such a programme of National importance is being organised in Goa by this Association.

I wish the Catholic Hospital Association of India all the success.

Sd/-
(Shaikh Hassan Haroon)



“Paco Patriarcal”
Altinho
Panjim Goa

Dated: 28th October 1980

MESSAGE

I am happy that the 37th National Hospital Convention and Exhibition 1980 organised by the Catholic Hospital Association of INDIA is being held at Old Goa from the 28th November to 1st December 1980. This is the first time that a Convention and an Exhibition of this order is being held in this Territory, and we the people of Goa are indeed proud.

Health is the birth-right of every human being and therefore I congratulate all those who have contributed in arriving at the decision that the theme of the Convention to be held here is to be on “RIGHT TO HEALTH”.

On behalf of this Archdiocese and the faithful of this Territory, I send out to the Organisers of the Convention and Exhibition as well as to the participants our sincere greetings wishing them at the same time successful achievement of the aims in view.

Sd/-
+ RAUL NICOLAU GONSALVES
ARCHBISHOP OF GOA AND DAMAN
AND PATRIARCH OF THE EAST INDIES.

MESSAGE

The Voluntary Health Association of India rejoices with the Catholic Hospital Association of India as you gather in your 37th Annual Convention & Exhibition.

Your theme, "The Right To Health", is an expression of a growing recognition among all people that moderately good health services can and ought to be available for everyone. As the physical possibility of providing health services for all becomes more realistic, we more clearly recognize the genuine human right to have a praiseworthy state of good health. This is compatible with the simultaneous awareness that death is also a stage of life.

Your theme is challenging.

The right to health calls our attention to the obligation of seizing every opportunity of growing into a high degree of wellness.

The right to health will remain ineffectual unless we recognize health not merely as a passive happening, but as a goal to be zealously pursued.

Our health is conditioned by our families and other people with whom we live. Our physical, social and cultural environments also help or harm our health. We need clean air and water, wholesome food and regular physical exercise. A cheerful, hopeful, creative and optimistic disposition are constant lifts towards good health. Anger, fear, depression and persistent guilt are demons that smother our growth and expansion.

For good health, the energy of love, devotion and service that ferments within ourselves needs outward expression and focus towards people with whom we live, the whole world community and the most Holy Trinity.

These are the ideals that lead us through healing to health and wholeness. Health in its fullness is of our whole person in all our relationships, physical, psychic and spiritual.

Health supposes that we have or create for ourselves a supporting atmosphere. Health is expressed as a radiation of our being that reaches out, desiring wellness for others, and fulfilment with others in oneness with Infinite Being, Goodness, Beauty and Love.

October 16, 1980.

Sd/—

James S. Tong, S.J.

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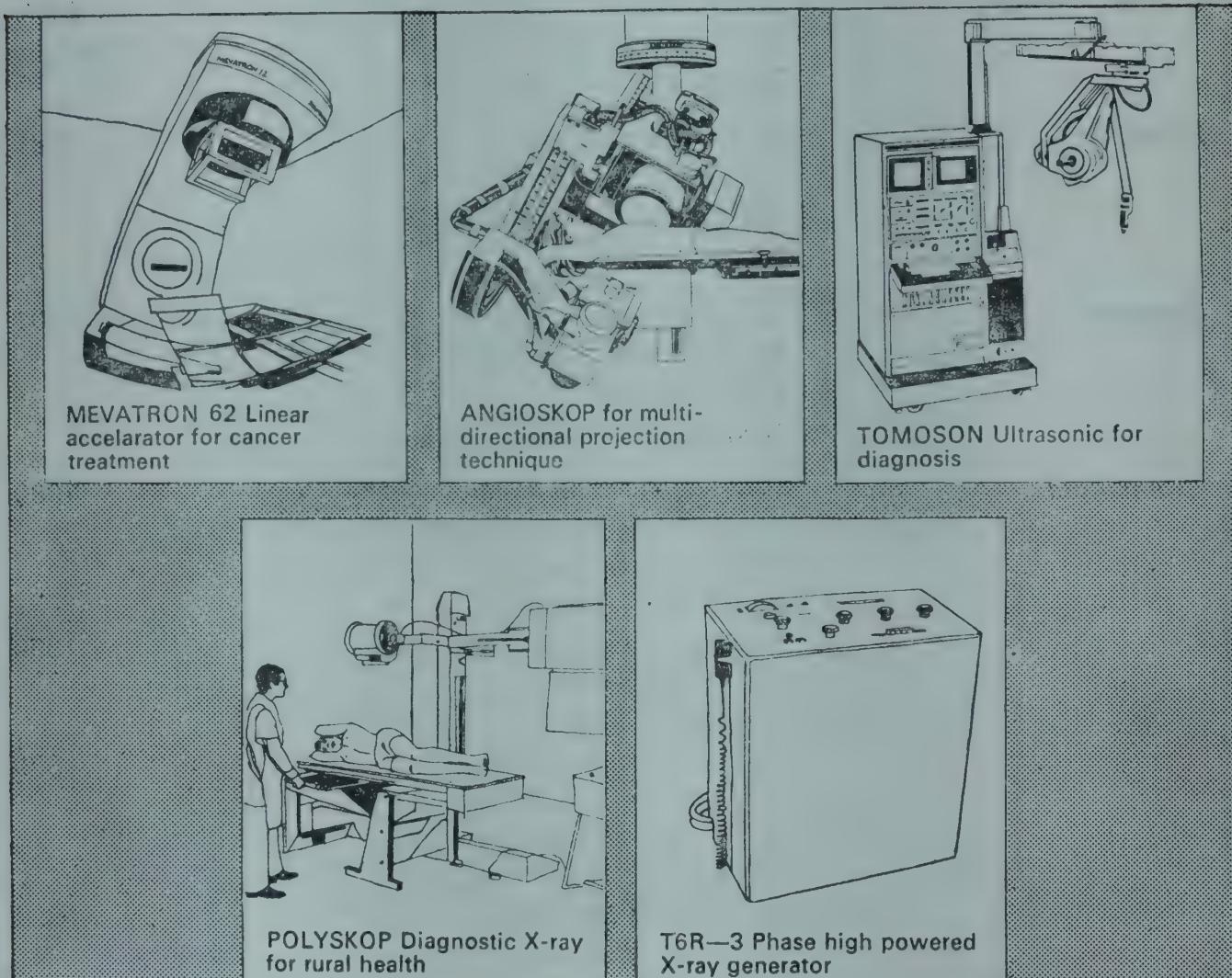
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Nov. 28th — Dec. 1st 1980

THEME :
Right to Health



EDITORS

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COVER

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National Hospital Convention & Exhibition 1980

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right to health : a myth or reality

fr. john vattamattom svd

On December 10, 1948, the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights. In Article 25 of this declaration it is stated that : *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social service, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."* The constitution of WHO and numerous Health Assembly resolutions have reaffirmed that health is a basic human right and a world wide social goal, that it is essential to the satisfaction of basic human needs and the quality of life; and that it is to be attained by all people. On September 12, 1978 the International Conference on Primary Health Care that was held in Alma-Ata in the USSR issued a Declaration calling for urgent national and international action to attain an acceptable level of health for all by the year 2000. All these point out to one reality that health is a fundamental right of every human being and the responsibility of attaining this rests with everyone particularly the rulers of the countries.

Against this reality are the naked facts. The health status of hundreds of millions of people in the world today is unacceptable. More than half the population of the world does not have the benefit of adequate health care. There is a wide gap between the developed and developing countries in their levels of health and in the resources they are devoting to the improvement of health. Again, within individual countries, whatever their level of development, analogous gaps are commonly evident between different groups of the population. Taking the situation in our own country, it is not different if not much worse. 80% of the health care institutions in our country are concentrated in urban areas where only 20% of our people are living. In many of our over 5 lakhs villages in our country, even primary health care remains a wishful thinking. After 33 years and more of our Independence and after 32 years of the Universal Declaration on Human Rights, millions of our people have to walk miles to fetch a pot of drinking water, let alone having sufficient water to keep themselves clean or to grow some vegetables for their consumption.

Health, here, is to be understood not as mere absence of sickness but the fundamental right of every man to keep his integrity. In this sense we can not speak of health as an isolated factor but as one important element of man's attainment of his wholeness. The aspect of his health is inseparable from his social, political, cultural, psychological, emotional and spiritual aspects. As far as the common man is concerned, the picture is darker when viewed against these aspects compared to the already bad enough purely health aspect.

When speaking of the right to health one aspect that needs special stress is the moral aspect. On the one hand declarations are proclaimed on fundamental human rights; on the other hand abortions, mercy killing etc. are getting legalised! It is here that we shall have to rise to the occasion and fight against the violation of basic human rights.

Considering all these, the question to be asked is : right to health : is it a myth or a reality ? If we analyse only declarations and statements, then it is a reality, but if we analyse facts, then we are forced to consider it as a myth. Perhaps more than ever today basic human rights are questioned and denied. It is a clear indication that mere declarations and statements can not solve the problem.

Is the future then so bleak ? I dare say no. For there are reasons for hope and optimism. The very ambitious goal of "health for all by the year 2000" of WHO is certainly a ray of hope. We need man who can look into the eyes of other man and recognise him as his brother, as his another self and do something for him. We need men who can take the health care services into the remotest areas, to the last man, because it is needed there. Our health care institutions should be prepared to go where it is needed and even risky rather than where it is convenient and profitable. Unless and until we are able to do this, **RIGHT TO HEALTH** will remain a myth. This is the challenge before our health care institutions in the coming years !



The Executive Director and Staff of the
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A Happy New Year 1981

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RIGHT TO HEALTH : A BASIC HUMAN RIGHT

By

**Joseph Minattur, M.A., J.D., Ph.D., LL.D. D.C.L., Barrister-at-Law
Professor of Law, University of Cochin.**

“...there is a consensus in world opinion regarding the right to a healthy life as a human's basic right.”

THE Universal Declaration of Human Rights adopted by the General Assembly of the United Nations on 10th December 1948 states that every one has the right to life, liberty and security of person.¹ It also states that every one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.²

The European Convention for the Protection of Human Rights and Fundamental Freedom also declares that every one's right to life shall be protected by law.³ It prohibits torture and inhuman and degrading treatment and punishment.⁴

The Fifth Amendment to the Constitution of the United States provides that no person shall be deprived of life, liberty or property without due process of law. An identical prohibition is enjoined on the

constituent states of the U.S. Federation by the Fourteenth Amendment. Similar provisions in respect of protection to life are found in the constitutions of almost all democratic states. Even Uganda which is not specially noted for its respect for human rights has laid down in its constitution that no person shall be deprived of his life intentionally save in execution of the sentence of a court in respect of a criminal offence.⁵ It also sets out in language almost identical to the language used in the European Convention a prohibition against torture and inhuman and degrading treatment and punishment.⁶ A number of African States which attained independence after World War II adopted similar provisions in their constitutions following the concept and in most instances even the language employed in European Convention. Nigeria led the way ; some African states including Uganda followed suit.

In the other hemisphere also one comes across similar constitutional provisions. For instance, in the Constitution of Barbados and Guyana provisions relating to protection of life and prohibition of

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torture and inhuman treatment have been adopted in terms almost identical with those in the 1960 Constitution of Nigeria.⁷ In South America the Constitution of Panama 1946 declares that it is an essential function of the state to look after public health and that the individual is entitled to the protection and conservation of his health and has the obligation to preserve it.⁸

Following in the main the provisions of the Universal Declaration to which India was a signatory, (apart from being induced by sparks of inspiration emanating from elsewhere) the Indian Constitution has laid down, among other fundamental rights enshrined in it, that no person shall be deprived of his life or personal liberty except according to procedure established by law.⁹

Interpreting the word 'life' used in the Fourteenth Amendment, Justice Field of the United States Supreme Court stated :¹⁰

By the term 'life' as here used, something more is meant than mere animal existence. The inhibition against its deprivation extends to all those limbs and faculties by which life is enjoyed The deprivation not only of life, but of what God has given to everyone with life, for its growth and enjoyment, is prohibited by the provisions in question...

Justice Subba Rao of the Indian Supreme Court quoted Justice Field with approval and endorsing his views regarding the connotation of the word 'life' applied them to the interpretation of the provision in Article 21 of the Indian Constitution which accords legal protection to the life and personal liberty of all persons.¹¹

The recognition of the right to health and its protection is not confined to what are sometimes referred to as liberal democracies. In some of the socialist republic the right to protection of health is more specifically predicated, making any judicial interpretation redundant, in understanding the general scope of the relevant provisions. For instance, the Constitution of Czechoslovakia in the chapter on Rights and Duties of Citizens provides that all working people shall have the right to the protection of their health and to medical care, and to material security in old age and when incapable of work.¹² This is in addition to a provision which requires the state to carry out an economic, health, social and cultural policy enabling the physical and mental capabilities of all the people to develop con-

tinuously together with the growth of production, the rise in the living standard and the gradual reduction of working hours.¹³ In Hungary the republic protects the health of the workers and assists them in the event of sickness or inability.¹⁴ The republic is envisaged as implementing this protection and assistance by means of a comprehensive social insurance scheme and the organisation of medical services.¹⁵ In Romania the state ensures medical assistance through its health units.¹⁶ These instances, it may be mentioned, are merely illustrative. They do not purport to be exhaustive of the provisions intended to accord constitutional protection to the right to the health in the socialist republics.

As similar provisions guaranteeing protection to life as understood in its comprehensive sense or, more specifically, protection to health, are predicated in virtually all democratic constitutions, it is obvious that there is a consensus in world opinion in regarding the right to a healthy life as a human's basic right.

Article 25 of Universal Declaration quoted above makes it clear that the signatories to the declaration were eager to spell out in detail the right to a healthy life as one of the human rights cherished by all mankind.

Following in the footsteps of the General Assembly of the United Nations the framers of the Indian Constitution set out the following provision as one of the Directive Principles of State Policy.¹⁷

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health.

Something not very different from this directive principle has been set out in article 92 of Constitution of Panama. The article enjoins the state to promote activities intended to combat contagious diseases, to establish hospitals, dental clinics and dispensaries in which services are rendered and medicines are given to the indigent, to protect motherhood and reduce infant mortality through medical assistance and adequate nutrition, to supplement the nutrition of needy students and to provide medical attention for school children and to popul-

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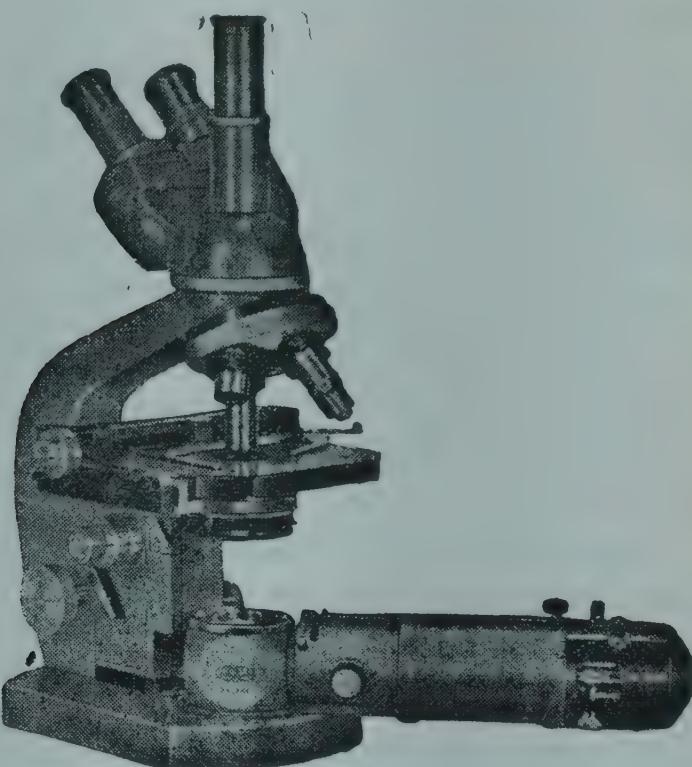
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Whether the directive principles in India should have predominance over fundamental rights in general may still be a matter of controversy and opinions may differ. But everyone appears to be agreed on the unhesitating acceptance of the constitutional provision that the directives are fundamental in the governance of the country. Improvement of public health, according to the directive principle quoted above, is one of the primary duties of the state in India.

Further, it is of interest to note that the right to freedom of conscience and the right to profess, practise and propagate religion guaranteed to every person under the constitution are subject, among other things, to public order, morality and health.¹⁸ One need not labour a point to prove the preferred

position the practice of religion has in the Indian way of life. When our secular state makes it subject to health, it is arguable that health is accorded a place more preferred than the one conceded to the practice of religion. However that be, it is clear from the constitutional provision what weight the founding fathers considered health should have in the scale of values in human life.

This basic right to health is sought to be implemented by various legislative measures in India. There are central and state enactments adopted with a view to promoting the health and social well-being of the people. Some of these measures may impinge on certain individual freedoms. Such measures are, however, considered necessary and valid because they tend to promote social well-being which is important not only to the society but also to the individual. They also sustain and promote a basic human right, the right to health.

Foot Notes

1. Article 3
2. Article 25
3. Article 2
4. Article 3
5. Article 18 (1)
6. Article 21 (1)
7. Constitution of Barbados, article 12 (a); see also 15 (1) which prohibits torture and inhuman and degrading punishment or other treatment. Constitution of Guyana, article 4 (1); see also article 7 (1).
8. Article 92
9. Article 21
10. *Munn v. Illinois* 94 U.S. 113 at 142
11. *Kharak Singh v. State of U.P.* AIR 1963 S.C. 1295
12. Article 23
13. Article 15 (1)
14. The Constitution of Hungary, article 47 (1)
15. *Id.* article 47 (2)
16. Constitution of Rumania, article 20
17. Constitution of India, article 47
18. *Id.* 25 (1)

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Medical Care Delivery Systems and Right to Health

By

Dr. S.V. Rama Rao, MBBS DPH MPH FRIPHH
Prof. & Head Dept. of Community Medicine
St. John's Medical College, Bangalore

'THE health status of hundreds of millions of people in the world today is unacceptable. More than half the population of the world does not have the benefit of adequate health care. There is a wide gap between the developed and the developing countries, between the 'haves' and 'have not', in their levels of health and in the resources they are devoting to the improvement of health. Moreover, within individual countries whatever their level of development, analogous gaps are commonly evident between different groups of the population'.

The existing Medical Care Systems in the world currently could fall basically into three types. The Public Assistance Type covering 49% of the world's population mostly in developing countries, Health Insurance, covering 18% in capitalist industrialised countries; and National Health Service covering 33% in socialist countries. There have been changes from one system to the other and virtually all systems have a trend towards some form of the National Health Service model. There are many forces impelling towards this change since the national health service to some extent has demonstrated its capacity for providing comprehensive

health services for every one in a rational and cost-effective manner.

There are many individual variations among different countries that have the same medical care system. More than one system can be found co-existent within a single country. There is a continuing process of revision and replacement.

Actually 108 countries with 1862 million population of Asia, Africa and Latin America with a few others have a medical care system which is by and large dependent on public assistance. India is one of them. The economy is primarily agricultural. There is an increasing growth of capitalist and socialist economic relationships. Whatever medical care is available, it is provided through mostly by government hospitals and health centres, financed by general taxation. The system and its facilities are generally under financed, overcrowded and have insufficient personnel. Physicians, salaries are generally low and they seek to supplement their income through other positions or through private practice. The services of full time physicians in the public system, therefore, are often part time.



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In addition to the public assistance system administered by Central and State Health Departments there is the Employee State Insurance Scheme for industrial workers operated with social security as the guiding principle. Though agriculture happens to be the main industry, it is just outside the scope. The Central Government Health Scheme takes care of a small white collared group of employees in Central Government. Voluntary agencies like Christian missionaries have established and maintaining hospitals and health services of a high standard not only in urban areas but also in some remote parts of the country especially rural and tribal areas where the poor and the underprivileged live.

There are also a small population of professionals, business community and concerns, officials, landowners etc., who use private physicians in their Nursing Homes and Clinic.

The needs and demands of population in respect of their Health Care has not been met even after 30-35 years of independence. There has been a growing dissatisfaction and a cry for the minimum primary health care to all.

India has a vast population almost reaching 700 million of whom 80% are resident in rural areas with agricultural economy. 13,000 medical graduates are currently coming out of more than 106-107 medical colleges every year in the country. Only 68% of these graduates are working in cities and larger towns catering to 20% of the population. 80% of the remaining rural population is looked after by the remaining 32% of the doctors. According to Dr. V.T. Gunaratne, WHO, SEARO, 'we now have an incredibly expensive health industry, not for promotion of health or prevention of disease but for the unlimited application of 'Disease technology' to the affluent section of the society. This distortion of health care delivery is self-perpetuating. The whole unhealthy system finds its most grandiose expression in buildings, in disease palaces (hospitals) with their ever growing need for highly skilled staff and sophisticated equipment'. 109 million town dwellers spent Rs. 4030 million or an average of Rs. 37 per head, and the 437.79 million villagers could spare only Rs. 470 million, of about a rupee per person per year on health. An overwhelming majority of Indians cannot afford the drugs produced by the sophisticated, high costs, pharmaceutical industry. About 20% of the people living in urban areas got 80% of health services. An average

Indian spent only Rs. 8/- per year on drugs and medicines prepared by the organised pharmaceutical industry in 1971. It increased to about Rs. 12/- in 1979. One computation is that on an average, per capita expenditure in medicare and public health is also as low as Rs. 10/- a year. Another notable fact is that only two per cent of the current plan expenditure is earmarked for health and family welfare. This allocation is grossly inadequate in a country where the health service presents a dismal picture. The national nutritional monitoring bureau has found that 3/4 of the pre-school children have a body weight below 75% of normal for the age. Of these 23% suffered from severe malnutrition and 15% from Vit. A deficiency running the risk of possible blindness. India is a country with an infant mortality of 120-150 per annum per 1000 live births as against the 18-20 in developed countries. According to official sources malnutrition is the single largest contributor to this high rate of infant mortality. This is a sad reflection not only of socio-economic conditions prevailing but also of the standards of maternal and child care services. Life expectancy of child born in India is 52 years as against 70-75 years in some of the advanced countries. A survey of the National Institute of Nutrition shows that as many as 80% of the children are undernourished and only 3% have normal body weight. Another survey by the Indian Council of Medical Research of 7000 families reveals that only 15% of the parents are fortunate enough not to lose a child. There are 9 million people estimated as blind in India and these 8.4 million live in rural areas. According to WHO about 2/3 of humanity does not have access to the simplest of health care systems. At any time, there are an estimated 400 million people with Gastroenteritis, 250 million with Elephantiasis, 200 million with Bilharziasis, 160 million with malaria. 80% of all sickness and disease is attributed to contaminated water. We have not provided even protected water for drinking to majority of population and especially in rural areas.

In developed countries there is increasing evidence that medical services have very little to do with health. Automobile accidents, drug addiction including alcoholism, sexually transmitted diseases, obesity, many cancers, most heart diseases and most infant mortality — are primarily attributable to living conditions, ignorance, irresponsibility of the individual and not to inadequate medical services. In recent years the best hope of achieving any significant extension of life expectancy lies in

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the area of disease prevention. In the absence of major break through (e. g. cure for cancer) further expansion of nation's health system is likely to produce only marginal increase in overall health status of the American people.

The International Conference on Primary Health Care meeting in Alma-Ata on the 12th of Sept. 1978 expressed the urgent need for action by all governments, all health and development workers and the world community to protect and promote the health of all people of the world. The existing gross inequalities in the health status of the people particularly between developed and developing countries as well as within the countries is politically, socially and economically unacceptable. At this conference it was reiterated that the people have the right and duty to participate individually and collectively in the planning and implementation of their health care, which envisages the four dimensions of physical, mental, social and spiritual well-being. This attainment of positive health is one of the important ingredients of good life that a nation should assure for every citizen. India was one of the nations who gave active support to the deliberations at this conference. Health has now been recognised as fundamental right of every human being. The preamble of the constitution of WHO states. 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social conditions. The constitution of India gives sufficient importance and emphasis. Health without discrimination between rich and poor, urban and rural educated and illiterate, privileged and the underprivileged, politician and the agriculturist, those in power and those without power is what is proposed to be achieved by implementation of the programmes and policies giving priority to the immediate felt needs keeping in view with the available resources.

Only a few countries in the world have succeeded in developing their health delivery so as to achieve a wide coverage of their population. The magnitude of the problem has been assessed by various committees and today we have a draft of a National Health Policy which has the following short and long term goals.

Short-term goals

- i. to eradicate/control communicable diseases in the country;
- ii. to provide adequate infrastructure for primary health care in the rural areas in urban slums;

- iii. to utilise all available methods for health education and spread the message of Health and Family Welfare;
- iv. to utilise knowledge from different systems of medicine for providing quick and safe relief from sickness and debility at the cheapest possible cost;
- v. to reorient medical education to be in tune with the needs of the community;
- vi. to provide increasing maternal and child health coverage.

Long-term goals

- i. to improve public health services by setting up a chain of sanitary-cum-epidemiological stations;
- ii. to ensure 100% coverage of all segments of population with preventive services;
- iii. to create a self-sustaining system of health security so that earnings of the individuals are not affected adversely during periods of illness;
- iv. to impart medical education in a medium which is an integral part of our culture and life-style and thus remove the foreign concepts associated with foreign languages which are major factors inhibiting people from understanding the true and proper role which medicine plays in the development of a healthy community;
- v. to utilise available knowledge from the ancient and modern systems of medicine in an effort to develop composite system of medicine, thus obliterating the caste system prevailing in the field of medicine;
- vi. to include a sense of self-reliance and discipline in all segments of population so that all sides of the health square, namely, prevention, promotion, cure and rehabilitation are effectively handled at the local level consistent with the developments in the field of medicine.

A main social target enunciated for implementation at the Alma-Ata conference was the attainment by all people of the world by the year 2,000 of a level of health that will permit them to lead a socially and economically productive life. Formulating strategies for health for all by the year-2000 has been the concern of WHO and guiding principles and essential issues have already been well laid and projected.

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“Primary health care is essential health care (promotive preventive, diagnostic and curative services) based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the country. It is the first level of contract of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (WHO).

The Government of India is attempting to deliver Primary Health Care services to the vast majority of its population through their network of nearly 5,400 Primary Health Centres with their subcentres. It is planned to deliver health services at the doors of the villagers by involving 580 lakhs of community health workers and another 5.80 lakhs of ‘dais’ after a short term training. One male and one female multipurpose workers look after a population of 5,000 people and there will be one community Health Worker for a population of one thousand. These community Health Workers are to be selected by the community itself and trained in batches at the Primary Health Centres to which they belong.

The Community Health Workers will be taught the fundamentals of Health Services, measures of maintaining health, methods of health education, treatment of common and minor ailments first aid, immunisation etc. The Community Health Workers have been working for some time and a preliminary evaluation has revealed that the initial response from the community has been satisfactory. About 22% of the Community Health Workers however have been posing themselves as doctors and attending mainly to treatment of sick which is not very encouraging. Government of India has an outlay of Rs. 486 crores in a scheme to take health care to villages over a period of 4 years.

The Community Health Workers’ Training Programme has been organised in our Institution—St. John’s Medical College and associated teaching hospitals/rural health centres. It is a coordinated effort. Our CHWs will Join the army of CHWs and multipurpose workers being trained by Government

to develop, expand and extend primary health care service in rural areas and urban slums. They will function as essential links between the country and established health agencies to make rural health programmes a reality and effective. This programme has been taken up by St. John’s Medical College as a result of the intense desire of the CBCI Society for Medical Education to train persons to meet some of the urgent needs for the Society. So far more than one hundred workers have been trained in 6 batches. From an evaluation of their involvement and participation in Community Health Work after their training, it has been found that the training has not only been rewarding but also effective. Community Health and Community Development go together. It concerns values such as social justice, loving, sharing, caring, compassion and being committed to those who are poor and those left out from society. We have found that these qualities are abundant in the band of Community Health Workers who are selected from religious orders and who come for training to us at St. John’s Medical College. Without these qualities a Community Health Worker is ineffective and dangerous.

Every human individual born has a right to health and any medical care system worth its name should attempt to deliver the Primary Health Care especially to the vast majority who need and who cannot afford. Let us hope that ‘Health for all by the year 2000’ would be a reality and not a mere slogan for publicity and propaganda in the hands of politicians.

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What is health for all ?

**By Dr. Halfdan
Director General, WHO**

IT is only four years since the idea of health for all by the year 2000 was first put forward at a number of WHO's Regional Committees. Since then it has fired the imagination of people throughout the world. It has also given rise to severe scepticism. "How do you define health ? What do you mean by all ? Will no more babies be born with inborn diseases ?

When the Thirtieth World Health Assembly in 1977 decided to adopt health for all as the main social health target of governments and WHO for the coming decades, it referred to it *as a level of health that will permit people to live a socially and economically productive life*. Such a life is also not easy to define precisely. Yet it is those who live such a life who tend to be the sceptics and who demand explicit definitions, whereas those who live an inferior life, or represent people who do have become inspired by a new hope and a new determination to work towards better health.

If health for all meant medical repairs by doctors and nurses for everybody in the world for all their existing ailments, much in the same way as mechanics repair faulty motor-cars, it would cer-

tainly not be a realistic proposition. But it does not mean that. Nor does it mean that nobody will be sick or disabled, *It means a different approach by which health is considered in the broader context of its contribution to, and promotion by, social and economic development*, so that all people will be able to lead socially and economically satisfying lives. It means that people will use better methods than they do now for preventing disease and alleviating unavoidable disease and disability, and better ways of growing up, growing old and dying gracefully.

Today nearly one thousand million people, living mainly in rural areas and urban slums, certainly do not live satisfying lives, since they exist in a state of social and economic poverty. This is a pernicious combination of unemployment and under-employment, economic poverty, scarcity of worldly goods, a low level of education, poor housing, poor sanitation, malnutrition, affliction by disease, social apathy, and lack of the will and the initiative to make changes for the better. Taken together these create a vicious circle, and improvement of any one of them could contribute to improvement of all of them.

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It is for these people first and foremost that the concept of health for all is so important. However, it is not for them exclusively. No people can be entirely satisfied with their social and economic productivity. As they move forwards along the road of social and economic progress they strive to improve their lot; they would not be human beings if they did not. But in the past, in trying to do so, they have committed gross errors in their relationships with their environment. In this way they have brought on themselves retributions in the form of slowly developing but insistent ill-health, such as lung cancer and cardiovascular disease as a result of over-smoking, high accident rates, mental illness to the extent that vast numbers live on tranquillizers, and high suicide rates in those countries that consider themselves among the most socially advanced.

In short, *health for all aims at all people whatever their present level of social and economic development, but social justice to the underprivileged*, so that they become able to extricate themselves from the poverty equilibrium in which they are trapped. As they do so, they will be wise to progress in a way that does not lead them into another trap—that excessive medical consumption as part of a consumer society. Health for all is thus a moving target. As a certain health status is reached, people will try to reach a higher level, and so on.

The approach that is being adopted to attain health for all is based on the fundamental understanding that health begins at home, in schools, in the fields and in the factories. It is there, where people live and work, that health is made or broken.

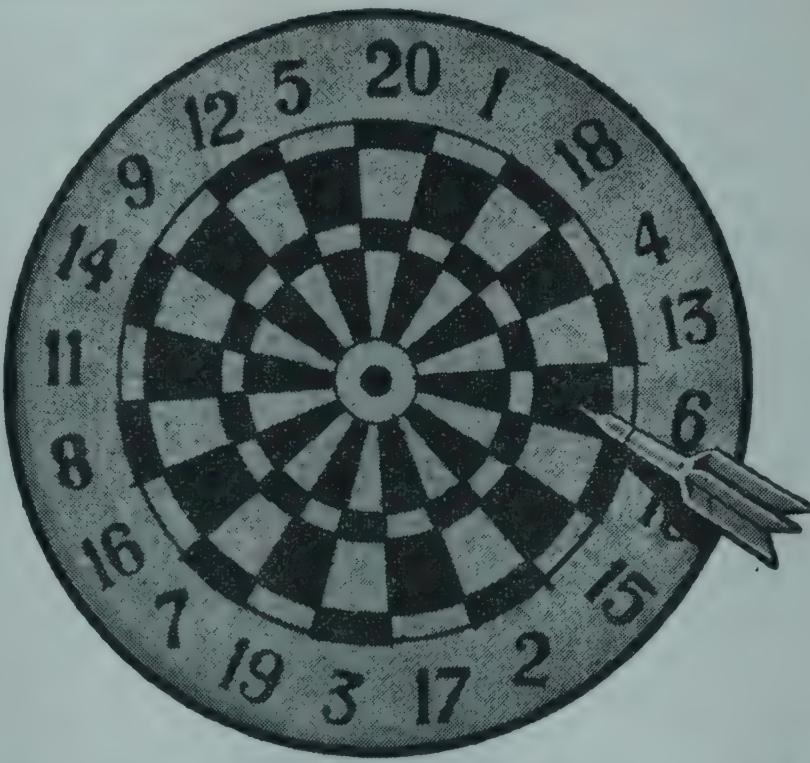
People must therefore understand what health is all about, and it is the duty of those who know to help others to understand. People must grasp that ill-health is not something that is inevitable, and that to bring about better health proper account has to be taken of a number of factors of a political, economic, social, cultural, environmental, and biological nature strengthened by this understanding, people will be in a better position to exploit those factors that are favourable to health and to combat those that are detrimental. But to gain progressively such an understanding a minimum level of health is essential. So health and social awareness must go hand in hand, the one leading to the other and each progressively reinforcing the other. The process I have just briefly described is known as *community involvement*, or as somebody has expressed it, "health as if people mattered".

Such community involvement can have a broader influence than the local organization of health care. It can be instrumental in bringing about *the commitment of community leaders to support the health reforms required* and through them can stimulate the political commitment of their government to introduce and sustain these reforms. For, in the final analysis, governments do have responsibility for the health and socio-economic developments of all their people, and not only of the elite in the main cities. This implies *distributing resources for health more evenly*, and to do so means giving top priority to the socially under-privileged. This applies within countries, but also applies internationally, since the more fortunate countries have a double responsibility—to their own people and to those in countries in less fortunate circumstances.

Government decision and popular insistence are also necessary to ensure that many sectors in addition to the health sector take the necessary action to promote health. For example, the education of the masses, the provision of safe drinking-water and adequate sanitation, adequate supply of the right kind of food, and housing that shelters against excessive sun and rain and wind, and gives protection against insects and rodents usually depend on actions in other sectors as well as in the health sector. The involvement of people in ensuring this action is just as important as their involvement in action within the health sector. The latter has to ensure maternal and child health care, including family planning. It has to deal with the provision of immunizations against the major infectious diseases and to take other measures necessary to prevent and control important local diseases. At the same time, it has to deal with the treatment of common diseases and injuries as well as with the rehabilitation of those left with disability. Rehabilitation also requires action in sectors other than the health sector. So does the provision of essential drugs. This calls for industrial and commercial action in addition to the careful selection and quality control of those drugs that are really essential. For most purposes these could be reduced to far less than 200 in most countries.

How much will it cost ?

THE above describes the minimum requirements for moving forward in the direction of health for all by the year 2000. Are the costs exorbitant ? Recent small-scale studies have shown that *considerable improvements in people's health can take place for as little as 0.5 to 2 per cent of the yearly gross*



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national product per person—or what amounts to a few dollars a year. This is by any standard a reasonable cost, around a hundredth of what is spent on health by people in many rich countries. So cost factors should not hinder governments when they consider if, and to what extent, they should commit themselves to the target of health for all by the year 2000.

So this, in a nutshell, is what is meant by health for all through primary health care. If countries strive towards health for all in this way, and avoid creating the kind of medical consumer society that exists in the developed countries they will be able to make progressive improvements in their provisions for health at a cost they can afford. This must include support for primary health care from the more central tiers of the health system. In too many countries today, resources are first allocated to central medical institutions that provide sophisticated and costly medical care to the privileged few, only a small fraction trickling down to people where they most need them—in their homes and in their communities. The education of health workers too is concentrated in these central medical institutions, producing health workers who are quite divorced from most health problems of most people. The correct approach to attaining health for all therefore includes *training health workers to be socially attuned to the needs of the people they are to serve, the technically equipped to help these people understand what health is all about and to provide them with the care that need, where they need it and when they need it.*

The developed countries too will require enlightened community involvement as well as government commitment to introduce the health reforms required to reshape their health systems. These reforms will have to include adequate measures to combat over-smoking, over-eating, over-drinking, over-using and abusing drugs, over-pollution of the environment, and over-stressing and over-alienation of people in gigantic urban agglomerations. At the same time they will also have to include giving up the attempt to provide everybody with every type of medical technology currently in vogue, which even the richest countries cannot afford, and which would not be of real benefit to their people even if they could afford it.

In September 1978 the International Conference on Primary Health Care that was held in Alma-Ata in the U.S.S.R. issued a Declaration calling for urgent national and international action to attain an acceptable level of health for all. No time has been lost by WHO in setting this action in motion. The Member States of WHO are about to embark on the development of strategies for attaining health for all, individually as far as their own countries are concerned, and collectively for regional and global strategies in support of national strategies.

In involvement of the world community and the commitment of the world's political bodies are crucial for ensuring the success of these endeavours. *For we must succeed. The children of today, and those who have not yet been born but who will comprise more than one-third of the people living in the year 2000, will never forgive us if we do not.*

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Community Health as Tool for People's Organisation

By S. R. AROLE

The present system of Medicine is inadequate to meet the health care needs of the rural India. An alternative system which will bring health services to the Villager's door-step at all times, cheap enough for him to afford without robbing him of his dignity is imperative.

The present system

We live in two republics : one is the Republic of India and the other "Republic of the elite island of India", and in the latter the people have prospered, preserved and developed themselves without any obstruction. These elite are recipients of sophisticated medical care.

A prominent Professor of medicine who has been a member of teaching faculties in India and Iran, is convinced that the present system of medicine in India benefits only one group, viz. the medical profession.

Let us look at our plans and programmes since 1947, when we had hardly 20 medical colleges with only 1200 students. Today our 106 medical colleges churn out 13,000 doctors every year trained in the so called modern medicine, not to mention an equal number trained in the Ayurvedic and Unani systems. But we have the dubious distinction of harbouring a fifth of the world's lepers and having infant mortality of 100 to 140 per thousand whereas

in a little country like Sri Lanka it is barely 45 per thousand.

In other words, while we get more and more doctors and the elite can afford the very best care in the world, the poorest in the rural areas where over 50% exist below the poverty line, are deprived of basic health care. Like land and other riches, health care too is a reserve of a few and does not reach those who need it the most.

The inequality is caused precisely because the basic medical knowledge has been kept away from the poor. Medical care is available to those who can afford to pay, and is withheld from the deprived sections. As Kishore Saint said in his keynote address at International Convention on People's Participation in Development, organised by I.S.I., March 10-13, 1980, there is an ocean knowledge, technical knowhow and culture, but without benefiting common people.

The poor cannot afford the high cost that is attributable to the proportionately high salaries

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demanded by the health functionaries, use of expensive and often irrelevant equipment for simple diagnosis and profit-oriented drug industry. We invest Rs. 100,000 to produce a doctor who also requires a lot of investment in terms of equipment and a wealth of drugs. The doctor is likely to prescribe expensive drugs.

Now we have heard the descriptions of these tribals and Harijans who hardly have sufficient food to eat. How would one expect them to afford medical care? Because of low income in the rural sector, most health personnel and facilities are concentrated in the urban areas. The rural needy are forced to transport the sick to the towns, and in the absence of regular public transport, they have to use expensive private transport. How would those who do not have sufficient money to buy food afford all this expense? Thus, the high cost of medical care geographical isolation, communication gap between city-trained health personnel and simple villagers and extreme differences in the lifestyle of comparatively well off health personnel and the poverty stricken recipients of health care are some of the barriers that prevent meaningful and adequate health care from reaching the rural poor.

The second important factor is the drug industry. Its turnover in 1947 was Rs. 70 crores while today it is 850 crores. Once the drugs are produced, the industry has to find those who can sell them to the people. Their markets that were mostly in the cities are slowly invading also the rural areas. Drug industry salesman often influences prescription of rural doctors. We are told that in Tanzania, for every four doctors there is a pharmaceutical representative. Even in a country like England, for every 20 doctors there is one medical representative. They say that in Tanzania the amount of money spent for medical education or for medical care is surpassed by the amount put in for the advertisement for drugs every year.

The present medical system is of the curative type, but most of the health problems in rural areas originate from malnutrition, lack of safe drinking water, poor environmental sanitation, harmful taboos and traditions and social injustice. Simple ailments progress to serious illness as no one is available to intervene at their onset.

Yet the drug companies will not produce enough vaccines that are essential to preserve the life of the children and mothers. They will not produce

anti-tuberculosis drugs, though TB is Number One killer among India's adult population. 25% of drugs production are vitamins and nutrients. A man who has enough money to consult a doctor has enough to eat and does not need vitamins as the first priority, which means that he does not need this type of medical services. So not only are the people made to spend unnecessarily, but more important still, the scientific manpower which can be doing research on and production of life-saving drugs is unnecessarily utilised for doing something less important. In India we are very proud of the fact that the third largest scientific community exists in our country, next only to USA and USSR. But they are not utilized for doing the type of things that are essential to bring down infant mortality which is extremely high.

Need of alternatives

There is a need for an alternative system which will bring health services to the villager's doorstep, make them available at all times and in all seasons, make them cheap enough for him to afford (or for the government to afford on a national scale) and provide this care without robbing him of his dignity. This in itself is a tool to make him aware of this deprivation and to take appropriate action.

I am glad that the programmes presented at the convention and others tried out elsewhere show that these objectives are relevant. All of them have tried to bring health closer to the people and make them feel more human. All the programmes mentioned here have tried to help the villagers, the Harijans and the Tribals in particular, who had been deprived of their human dignity, to regain it through their own community's efforts.

In our programme at Jamkhed, when we started in 1974, we aimed at providing primary health care to all, reducing infant mortality by 50%, providing adequate antenatal and maternal care, reducing birth rate to 30 per 1000, bringing the chronic diseases such as leprosy, and tuberculosis under control and preventing blindness. Our programme operates in 70 villages covering a population of 80,000. Since this is an expanding dynamic programme, the population served does not remain static.

All other programmes mentioned in this paper had similar aims when they first started. Most of them have a three tier approach though the way it is organised may keep changing. The first tier consists

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of the Village Health Worker resident in the village. The second tier is a mobile health team visiting each village once a week as at Jamkhed and Kottar, or the dispensary that works as the first referral centre of the VHW and guides the village worker. In both cases it is the immediate support of the VHW and takes over where she leaves off. If it is a mobile team, then it treats some cases on the spot. If it is a dispensary, then the VHW refers some of these cases to it. Health education becomes easier with a mobile team than with a dispensary since the people see the support which the VHW receives from the team which can confirm the villagers into the new attitudes attempted by the VHW.

The third tier consists of the health centre at Jamkhed or the hospitals in other programmes like Kunkuri. The Jamkhed health centre has diagnostic facilities and arrangements for emergency care and in-patient beds. More serious cases are referred to the government hospitals. The other projects have got their own hospitals.

Some of these programmes, like the one of Berhampur, are still at an early stage and seem to concentrate primarily on health care. But from the beginning they have to have their sights clear: health is only a tool for the development of the people. It has to become a people's programme. Through health care the village communities have to build up a leadership and have to come together to fight against their exploitation.

They have already made a beginning though the results may be felt more in some places and less in others. In some places, as in Jamkhed, local leaders are involved in educating the people about their health needs. An advisory committee (called Famers' Club) consisting of local leaders and representatives of various groups guides the health professionals in the planning and implementation of the programme. They choose their own VHW from among those who volunteer to do this work.

If the people consider it their own programme, then they also maintain it materially and financially. Initially some external aid may be required. But it has to be only a temporary phenomenon. If the programme has to be effective, then the people themselves have to look after it and in most programmes they do. The Health Insurance programmes of Kottar of Mr. Nandan Bhattacharya in Calcutta and the RAHA of Kunkuri are

by and large self-sufficient. Berhampur, being only two years old, still has to reach this level. But it probably will in the near future.

The methods used for self-sufficiency keep changing, but they are people-centred and as such, depend on the capacity of the local population. In the Jamkhed programme, for example, each individual village council provides simple building for health activities. The infrastructure varies according to their ability and interest. Some may provide a simple room, others may make the community hall available for this purpose, and others still have to put their money labour together to put up a special building for health activities. To support the medical programme, there is an integration of development activities such as agriculture, provision of safe drinking water, employment schemes, rehabilitation programmes for the chronically ill—all of them part of their non-formal education.

The health team

a. The village health worker (VHW)

In all these programmes, the local village community (or the slum community in the Bombay programme) selects a volunteer, very often a woman to act as VHW. In most of these cases basic education is not considered important. In the Jamkhed programme, 50 out of 70 VHWs are illiterate and none has reached high school. One finds a similar proportion in the Berhampur programme. Literacy being higher among the Kunkuri tribals or among the Bombay slum dwellers, there may be better educated VHWs among them. But except in the city slums, in no other programme have people paid much attention to the person's formal education. Other qualities seem to get priority. Persons with leadership qualities and among the tribals, women who have passed through the Grahini schools seem to get preference. This training seems to add to their leadership qualities.

While selecting a VHW the villagers should be helped to beware of certain pitfalls. The VHW should preferably be a married, middle aged woman, with life experience such as bearing children and raising them. This is not always followed. Some programmes have selected young girls who have passed through the Grahini programmes. The effects of selecting these persons need to be studied, and if found unsuitable, proper precaution taken in future selection. If found suitable, this will give the villagers a much broader choice.

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Good People to Grow with

More than any other quality, attention has to be paid to the person's motivation and genuine concern for people. She should be someone who can be trained to shed her caste differences and enter into any house in the village. Care must be taken that the community does not select a figurehead. Often the Panchayat may suggest the Sarpanch's wife who is looking only for prestige and money. This can be avoided if all sections, particularly the poor, are involved in the decision making process. Right from the beginning they should realise that this work is an honourable one and not meant only for the Harijans.

At Jamkhed we prefer the VHW to be a woman since she is known to be hard working, trustworthy and above all one who is eager to learn and willing to change herself and others. Since she is married, we are careful not to keep her away from the home and village for a long time. Hence we try to adapt her training to this need too. Initially, after the local community has recruited them, they are brought to the centre for one week's orientation. Thereafter they come for two half days every week. Other programmes here have a different length and system of training. Whatever the approach, it is important not to disrupt their family life and not to meddle with their culture.

One of the ways of training illiterate persons is to start from cases they encounter during the week or the centre itself encounters. This can make their studies a concrete part of their experience, not textbookish. Whatever the method, their training has to be geared to the priorities we have mentioned above. Emphasis has to be on promotion and prevention of diseases and in methods of diagnosis and treating minor ailments. But apart from the technical aspects, they have to receive sufficient training in the social sciences.

Such training is required in order to help them to understand their social environment and change it when necessary. Take, for example, superstitions and taboos which we, health professionals, are used to talking about. To the VHW it is something she has to live with everyday and herself accepts sometimes. The training has to deal with this aspect by discussing them freely. Not much can be done if she herself is not convinced that many of these beliefs have no meaning or are positively harmful.

The trainer has to be careful not to rob her of her dignity by laughing at her ideas or by belittling

her. This has to be done through appropriate examples or by helping her to realise the interests behind such beliefs. The demonstration of acid fast bacilli of leprosy often convinces her that leprosy is not a divine curse. Once they are convinced of it, the VHWs become the most ardent promoters of change.

Another important aspect of the social environment they have to be helped to face is the caste system which is a major factor in India. It does not seem to be an important problem in the Kunkuri and Berhampur programmes which are predominantly among the tribals. The Gram Vikas is trying to face this problem, but for the time being not in the medical field.

The other programmes have probably got to face it in their community health programme itself, but they have not mentioned it in their papers. Much as we would like it to disappear from our life, it is very much a part of our society and determines our social contacts. It is essential to face it squarely and deal with it rationally.

Our own experience at Jamkhed has been that VHWs are very much caste conscious when they first join the training course, but overcome it slowly as they come in close contact with the others. The VHWs range from Brahmins to Harijans, but they live together, cook for each other and eat together. As the barriers break down, they begin to understand each other. Lectures and demonstrations from the trainers only strengthen these new found beliefs and teach them to be compassionate, just and show special concern for the poor. In other words, this training cannot be only imparting of technical knowledge, but it is necessary to spend equal time on their social responsibility.

To put it briefly, the training of the VHWs has to be part of this community building process. It is thus two-way communication. The teacher gains knowledge about local beliefs and taboos, and the VHWs together with the teacher try to find ways and means of overcoming them. Though audio-visual means are used, concentration is on local folklore and local material. As the VHW gains knowledge, she is encouraged to make up her health education material. Flash cards are commonly used. Sharing of experiences and using rural experience help to a large extent.

The functions of VHW

Her primary role is to look after the health of her village, especially of the pre-school children and

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give the villagers health education accordingly. She has to keep an eye on the undernourished children, supervise the nutrition programme especially of the undernourished children whose weight, and arm circumference she takes and keeps a record. She organises an immunisation programme with the help of the community and treats minor ailments. Her main task is to make regular rounds of all the families apart from visiting those who need curative care. At Jamkhed she has to cover the whole village once a week, at Berhampur it may take ten days and elsewhere it may be as much as two weeks. But she has to be a regular visitor.

As a result of these visits she has a complete health record of every family in the village. She advises pregnant women on antenatal care. In the Jamkhed programme over 80% pregnant women accept her advice. She also gives advice on family planning and puts the women in contact with the health centre if they require help to practise it. She conducts deliveries and visits mothers in the post partum period. She also visits leprosy and tuberculosis patients and their families and follows them up.

b: The mobile team or dispensary

Most of these activities are conducted in all the programmes represented at the convention. Besides, the special care the VHW should bestow on the children, may take different forms. At Jamkhed she runs a creche and teaches children who do not go to school. At Kunkuri and Berhampur it may take the form of a feeding programme and something else elsewhere. But whatever form her services take, she is the main link between the village and the health professionals. When the health team visits the village as at Jamkhed, or when the VHW takes the patient to the dispensary as at Berhampur, she acts as the main leader. She knows the details of women needing care, sick children requiring immunisation etc. The main role of the mobile team or of the centre has to be to give her all the support she requires, provide an effective consultative and curative service and be responsible for those patients whom the VHW cannot take care of. It can also help the VHW since in many places it also has a social worker, apart from the nurse and even a doctor.

It is because of this close supportive role, that a mobile team that goes to village may be better than a dispensary on health centre based second tier. The dispensary can supplement the curative aspect of the VHW. But some of the projects men-

tioned have not shown how they continue the educational aspect started in the daily visits of the volunteer both in the health field in particular and the social field in general. This can be done only when the team goes to the village.

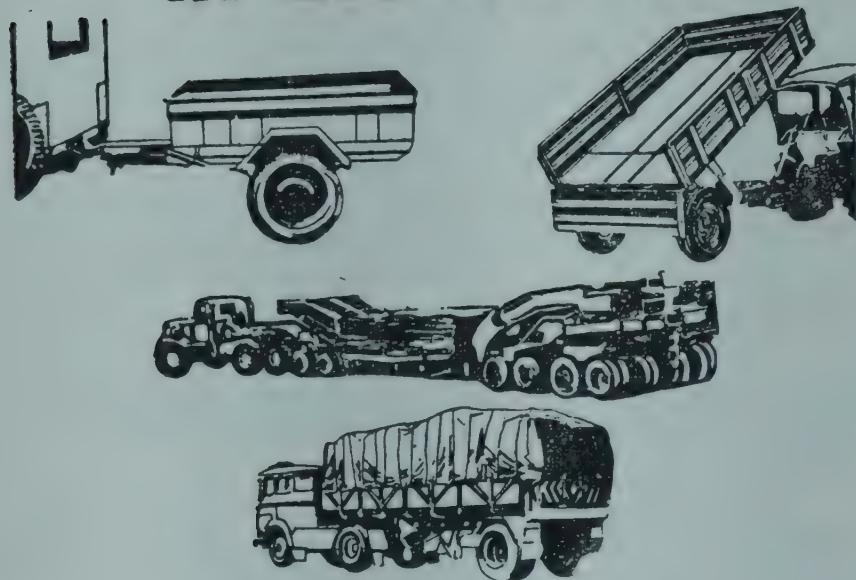
In the medical field, the nurse in the mobile team who is responsible principally for the health care of the mothers and children conducts antenatal clinic and examines every expectant woman and guides the VHW on her exact state. She may advise hospitalisation or counsel the volunteer on 'safe delivery'. She also sees all mothers and children needing special care, follows up the TB patients, examines and screens blind patients, and brings persons with mature cataracts to the health centre. She also conducts a curative clinic to which the VHW brings all patients who may require diagnosis. The paramedical team follows up in particular the leprosy and tuberculosis patients and helps with their rehabilitation.

Of much greater importance is the role of the mobile team in the social field. The existing leadership in the villages does not allow distributive justice in the health field just as in the others. The VHW can be trained to diagnose disease and prevent illness. But motivation to concentrate on the poorest cannot come easily when she is under pressure to attend to the upper classes in the village and neglect the others. Obviously, these pressures are greater in caste divided villages than in the tribal areas. Thus she herself may exploit people if she is not properly trained or is poorly motivated or adequately supervised.

That is where she requires the moral support, guidance and supervision from the mobile team. The second tier and the health centre have to give her good example in this by concentrating on those who would not otherwise get any care within the present medical system and social set up. It is also obvious from this that no system should rush to produce VHWs in a hurry but take time for proper selection.

This also brings to the fore the dilemma concerning the remuneration of the VHW. The ideal would be for her to be paid directly by the village community. Some programmes mentioned here do not have this system since the villagers have not been educated sufficiently as yet to realise that they have to compensate the worker. But some of them may also be facing the problem we did, because of which we pay her through the health centre rather

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than let the panchayat pay her Rs. 30—50 that she gets as an honorarium. The main reason why we at Jamkhed pay her through the centre is that many health problems stem not from medical causes as such (though they may be the immediate and apparent causes) but from social injustice and anti-social practices in the village. The role of the VHW is not merely to be a medical person but to be an agent of change in the village community. As such she should be in a position to deal with village leaders and panchayat members freely in solving such problems. If she were to be paid directly, there is the danger of her being under obligation to the sarpanch and often would not have the courage required to initiate change.

C. The health centre or hospital

That is where one has to find also the role of the third tier viz. the health centre of the hospital. Its work has to go beyond the medical field to the social problems and this concern has to be seen both in the training of workers and in the physical arrangement of the centre itself. Since the planning of health care is at the grass roots in the villages and the centre exists to solve these problems, the diagnostic and curative facilities are to be kept to the minimum. There should be no unnecessary expense on equipment or buildings which are not relevant to the project priorities. For example, the simple X-ray machine suits the purpose and one does not require very sophisticated machinery. Laboratory tests are limited to blood counts, smears for AFB and facilities for cross matching and blood transfusion. The operation theatre is mainly for abdominal emergencies, tubal ligation, obstetric emergencies, cataract and simple eye surgery.

We at Jamkhed have been able to live up to this ideal because our programme started as a community health approach and the whole infrastructure was built to suit this need. In many other programmes mentioned here, the infrastructure started as curative hospitals and dispensaries and were later adopted to the community health programme. Hence the physical arrangements may not be as simple as in areas that started as a community health project. While studying the replicability of these projects, this aspect has to be borne in mind and the physical arrangements have to be planned not according to a curative institution turned into an outreach programme, but to suit the needs of a community health approach. The programmes that have got very simple facilities use the government hospitals for more complicated cases.

However, the centre is not meant only to be a co-ordinating link for medical purposes but is a meeting place for all the villages. At Jamkhed the Young Farmers' Club meets there. We arrange seminars every three months where the club members discuss their problems, learn new techniques and meet 'experts'. The centre co-ordinates development activities in general, works as a place of encounter between the government officers and people, centre for family planning activities and education etc.

Some programmes seem to stop at purely medical aspects and forget that integration of all these activities and education of the people are essential even from the point of view of health care. If the VHW talks about better health care in the absence of social justice and the bare necessities of life, her talks are fruitless. Better nutrition, better conditions of living that result from these socio-economic factors contribute to the health situation. Therefore, it is essential to use these programmes as modes of social change and to provide more food, clean water and better conditions of living.

The village is not homogeneous community except perhaps in the tribal areas. Exploitation by various groups is a fact of life and the fruits of development rarely reach those who need it the most. It is important for the health centre to turn itself into a place where change in this system is co-ordinated and support given to the persons in the field.

What we notice from the experiences of those who have followed this process is that the poorer sections are eager to change their village and with this in view, organise themselves into Young Farmer's Clubs as at Jamkhed or into other organisations elsewhere. They are the ones who identify their needs which should be accepted even if they do not always agree with the priorities we set for them. At Jamkhed, for example, the felt needs they identified were water, food, shelter and employment. Their programme was geared to these needs and the educational process was integrated into it.

Care is taken that all socio-economic backgrounds are represented but that the initiative comes from the poorer sections and that the are majority belong to this group. In the meetings as well as in the development programmes, they learn to work together to change the situation of the most needy. They also try to improve the physical environment of the village in order to change its ecology. They come together as a group to carry out afforestation programmes. In 1976, for example, 10,000 trees

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were planted and watered through the summer. They support the agricultural operations through new techniques, loans for agricultural inputs for the marginal farmers and programmes for the landless labourers etc. Implements such as pump sets, sprayer, bullocks etc. are for collective use.

They also function as the supportive organisation for the health programme. They identify fallow land, bring it under cultivation and use its proceeds for the nutrition programme in their village. The club members themselves organise and conduct this programme and help the VHW in some tasks such as weighing children, arranging immunisation camps etc.

These groups together with the VHW, are the agents of change. Whether real change will come or not will depend on how they are guided. If supported and guided, they can build a better community. The social worker of the centre gives them constant guidance at Jamkhed. It may be some other person in other programmes. But if change has to come from inside, the villagers themselves have to become real animators and get support from outside.

It is not always possible to measure their achievements in physical terms. At Jamkhed the Young Farmers' Club had identified their needs in material terms, as such it is possible to measure some of the results in material terms. They have constructed 100 check dams, have levelled and cultivated 2000 acres of land, constructed, maintain and repair 104 tube wells for drinking water and have sunk 80 community wells for irrigation. But what matters is not merely the physical results, but above all the process of education in the community and the change of attitudes.

Training of the health teams

Training of the health staff is another major objective of the third tier. Great importance has to be attached to the regular training of the whole team, not merely of the VHWs as some programmes seem to be doing, because it is necessary for the patients to receive the same advice and health education from doctors, nurses and VHWs. Hence, all involved have to be trained together. It is essential for the second tier health team, for example, to work together as a body and at the same time co-ordinate its activities with those of the VHWs and the third tier.

This is not always easy. The papers presented at the convention have mentioned that they have diffi-

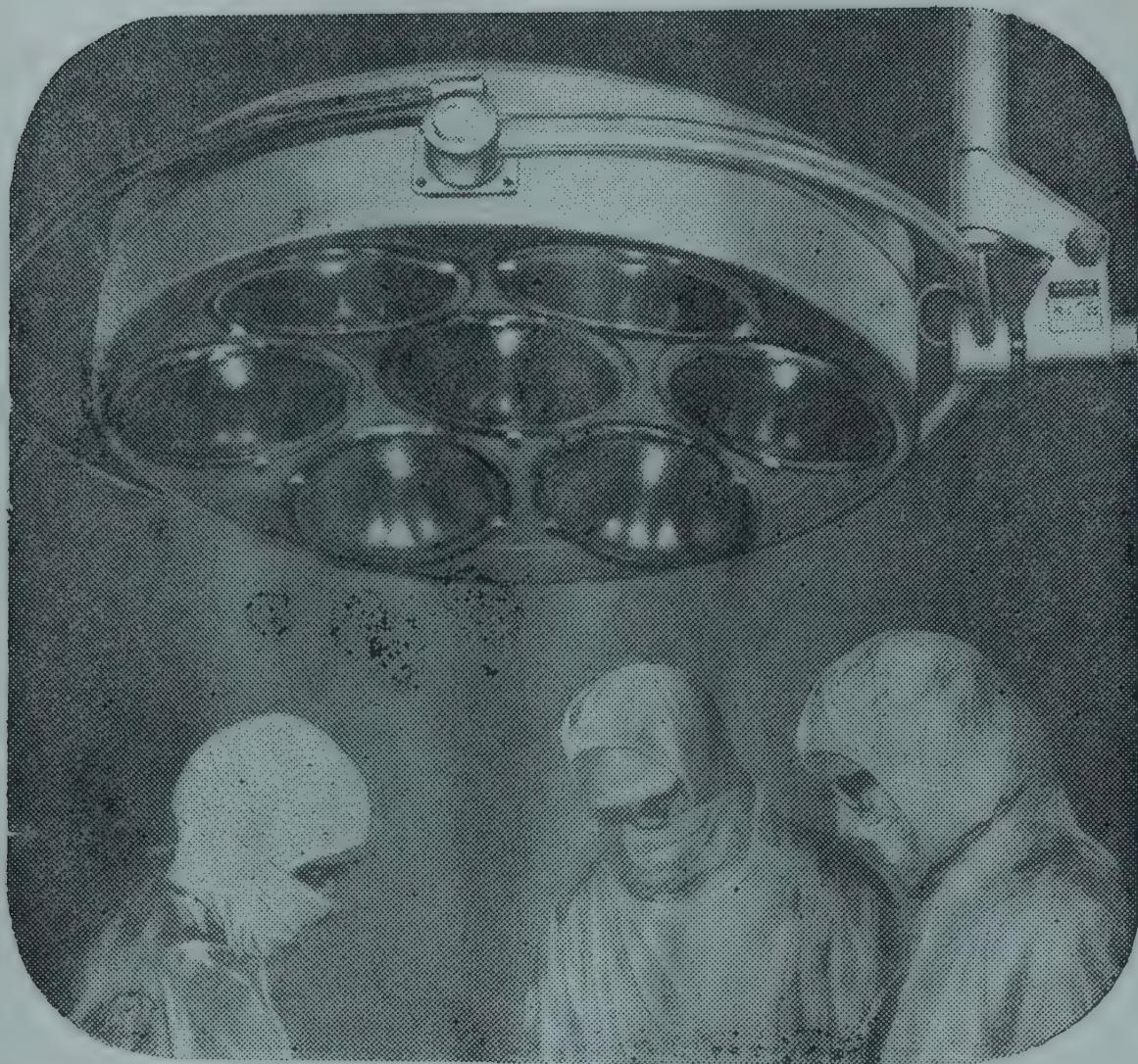
culty to convince doctors and nurses that ordinary illiterate women can be trained as health workers. We at Jamkhed have the same problem. Initially the nurses find it difficult to accept the VHW and even get jealous of her rapport with the community. To overcome these barriers, it is important to build the element of equality in the training of the team. Hierarchical behaviour is to be discouraged and horizontal relationship between the three tiers encouraged.

Delegation of responsibility from highly skilled to the less skilled is encouraged in most programmes but one is left with the impression that a few programmes have a centralised structure. Ordinarily, for a group to grow as a team and for the best effects in the field, interdependence of the three tiers needs to be encouraged. Nurses are to be trained to take care of the routine problems which the doctor attends to in the curative system. Similarly, nurses are to delegate responsibility to the less trained workers. This helps to multiply the bands of the health workers by deprofessionalising the medical system whose practitioners have deprived the underprivileged groups of health care by reserving knowledge to themselves.

Another important results of this training and of the system as a whole is a change in the status of women. The papers presented at this convention have mentioned that the status of women in India is often lower than that of the Harijans against whom atrocities are committed everyday. The health programme is one instance in which the women is lifted up from her day to day menial work and from an unskilled exploited worker, turned into an agent of change in the village community. Here we have a good experiment where the existing skills of the existing people can be used to change the community, instead of waiting for imported techniques.

It is precisely for this purpose that, as mentioned above, they are not let loose without any training. They are given the skills and are sure of support from the centre. They know that for what they cannot do, they can always rely on the centre. The centre also sees to it that they get continuing education. As a result they are probably better educated than many doctors who despise them and never read any medical magazines but only listen to the propaganda of pharmaceutical companies and prescribe drugs according to their dictates. The real success of the VHW still depend on the extent

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to which the medical practitioners truly involve themselves in their training and supervision.

My own experience has been that it is much easier to train these illiterate women than lecture in a post-graduate college. The difference is that while in a class room we professors also have an eye on our bank account, in the former we give priority to the people. The effect of a money-oriented system is that the medical student is looking for exotic visitors and exotic diagnosis. The more exotic the diagnosis, the more money he gets from his patients. Therefore, as long as the patient's illness and care relate to his capacity to pay, there will never be conquest of disease.

Replicability of the programme

One more element the organisers of the community health programme or for that matter any programme geared to social change have to bear in mind, is that their work is not to lead to an island of prosperity or health, but to create models which others can follow without too many external inputs. The replicable aspects should include choice and training of personnel, the approach to education and community organisation, the financial inputs and the whole infrastructure as well as the overall approach. Obviously, not every aspect is replicable. The educational strategy of the programme in a tribal area may not be acceptable to the village that lacks the same type of homogeneity but has great difference and inequality between the upper castes and the Harijans. Here we shall comment only on two aspects viz. finance and the need of research. The other aspects have been mentioned in the body of this paper.

a. Finance

While planning the funding of the project, it is important to bear in mind that it has to be done with an eye on the local financial constraints. Foreign or local voluntary aid may be required initially since it is very difficult to get government grants or local funds for new experiments. But all along the programme, the aim should be to make it self-sufficient and build the infrastructure in such a way that the government which has the responsibility for the people can afford it. Hence all extravagance and duplication have to be avoided.

Obviously, this observation does not hold good in the case of those who had originally started as

curative dispensaries or hospitals and later changed over to the community health programme. Their buildings and equipment were originally meant for a different purpose. The replicable aspect in their case may not be the material infrastructure but the process involved in the changeover of the system and their methods of training and building the local leaders through the VHJs and team work.

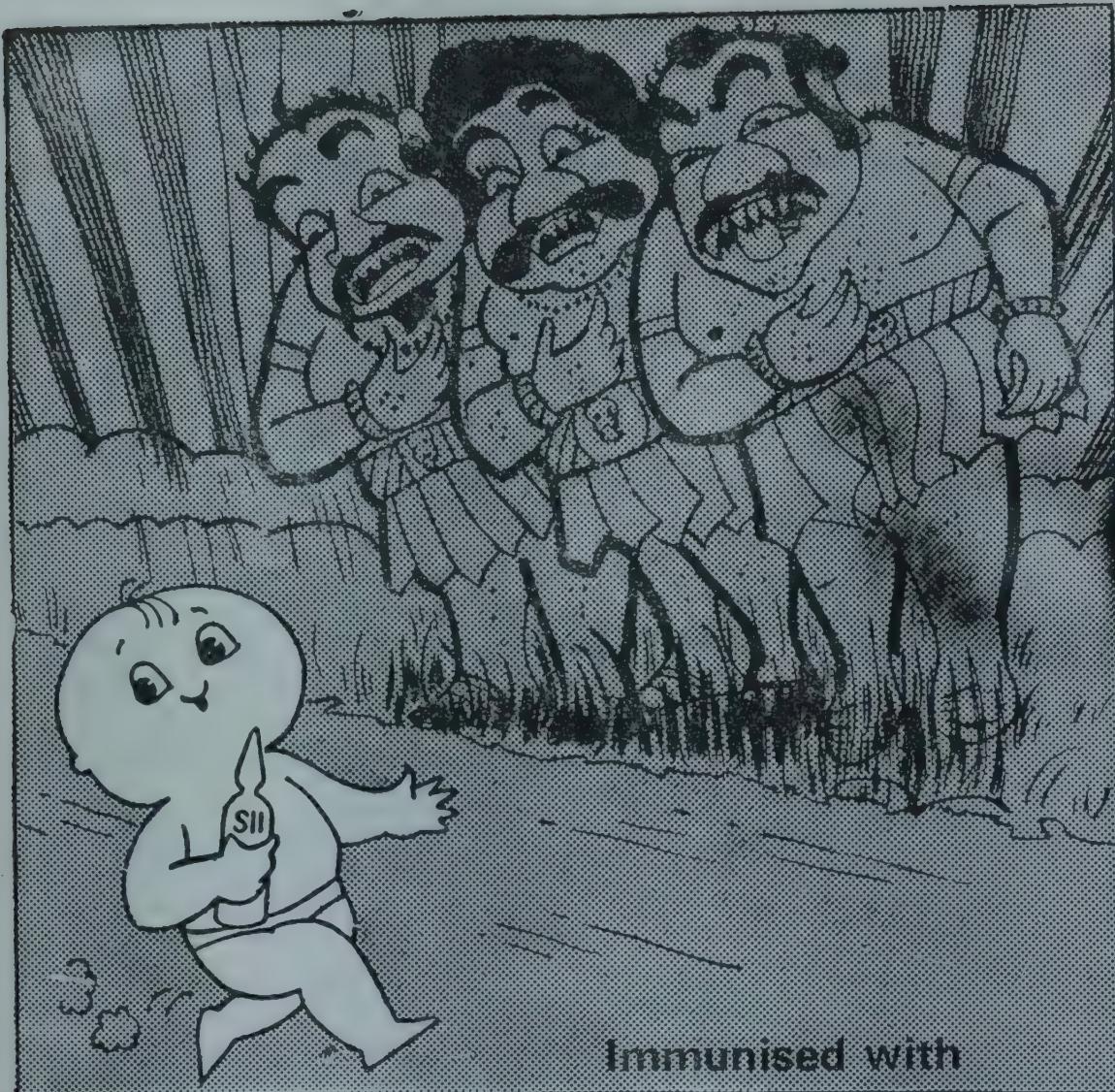
In our own work at Jamkhed, we had to get initial aid from various national and international charitable organisations to build the 30-bed health centre with an out-patient department, operation theatre, laboratory, X-ray facilities training centre and storage. We also got aid for the staff quarters, for our 30-strong team of the second and third tiers as well as for the health centre equipment for the X-ray unit, laboratory and other departments as well as the vehicles for the mobile teams.

This capital expenditure came to about Rs. 15 per capita. The recurring expenses are met by the people themselves since they view health care as a felt need. We collect nominal fees from the patients at the health centre. The annual cost of our programme is approximately Rs. 5 per capita. Only the leprosy rehabilitation work is subsidised by voluntary agencies. These agencies also help the people to start other community development programmes by supplementing local efforts where local resources are not available.

It is also important to see the proportion of each segment. At Jamkhed, 30% of the budget is spent for salaries of all personnel transport accounts for 20%, medicine 40%, administration, contingencies and training 10%.

b. Research

Both from the replication point of view and in order to convince professionals, I would request that the community health teams have some inputs in evaluative type of research. None of these programmes began as the result of research projects but as attempts of convinced individuals and groups to provide medical care to those who were deprived of it. Initially the objective was limited to offering elementary health services to the neglected masses. Later, most have gone beyond health to try out a new process of education. In most places the approach has been pragmatic and flexible. It is important to spread the message of this approach if more have to enjoy the fruits of the labour of a few pioneers.



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However, one should also remember that most of these programmes are situated in remote areas where not many professions are available for teaching and research. Hence most work has to be done locally and there has to be an inbuilt evaluation system. In most places those involved in gathering and recording information are nurses, social workers and the VHWs who are trained locally. All this data needs to be analysed, for when one looks at all the records, one sees the richness of the data available. The VHW, for example, keeps records of the vital events in the community—births, deaths, epidemics, the weight cards of under fives, list of children immunised, of women who undergo sterilisation, those who receive ante and post natal care, TB and leprosy patients the daily log book of illnesses treated etc. The mobile teams keep records of follow up work such as the morbidity surveys, health status or pre-school children etc.

By analysing all this data and through other action surveys, an effort should be made to study the impact of the programme on the health and nutrition status of the village as well as their social consciousness. Outside professionals may be involved for a few of these aspects. But our own experience shows that the ordinary worker can do this work. In fact, our experience has been that by teaching these women simple things and by helping them to do their work, they are capable of bringing infant mortality down from 120 to 45. Birth rate too has come down, undernourishment exists only among migrant workers' children, 80-90% immunised and diseases brought very much under control.

Conclusion

In conclusion, the following facts seem to emerge out of the various attempts to reach the rural masses with health care as the entry point :

1. Formulating clear-cut objectives and developing programmes accordingly.
2. Genuine grass root involvement of the people specially of the weaker sections.
3. The choice of the worker from the community, especially from the weakest sections since it

is not healthy for the programme to have great disparity in the life-styles of health providers and recipients.

4. Team approach by all the workers with great emphasis on the social responsibility of every team member, the well qualified professionals in particular, rather than merely technical competence.
5. Moving away from the teacher-taught mentality and willingness to learn from the illiterate masses and to win their confidence, as well as to share knowledge with the common man.
7. Realisation that health is not their priority. As such it should form part of an integrated approach to total development of the community.

We health professionals are in a unique position. We have access to all age groups, to all households. We share innermost feelings and emotions of people—share their sorrows and joys. Noble health professionals in India have given scientific foundation to modern medicine and built fine institutions all over the country. Unfortunately, we have reached only a segment of our population.

The challenge to us professionals is to take the fruits of modern medicine to millions of deprived people living in slums and remote villages. Because of our access to the people and their trust in us, we can be the agents of social change that is fundamental to bring positive health to the needy.

Will the dedicated health professionals accept this challenge and come forward to this new task? We possess immense knowledge and skills to bring happiness to those existing in dire poverty. Are we willing to share our knowledge and skills with these people? Could we help these people become self-reliant in their health activities and thus set pace for self-reliant development?

Reprinted from "Peoples Participation in Development: Approaches to Non-Formal Education" Edited by Walter Fernandes; Published by Indian Social Institute, New Delhi—1980

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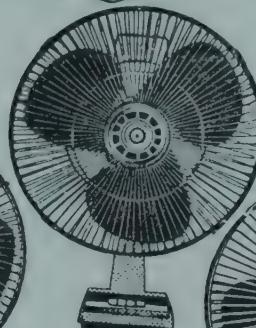
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Comprehensive health care

by Ms Rita Panicker

SOCIAL development is a growing science. It searches answers for human progress and stability. Every effort made towards solving the problem of backwardness and poverty helps to make us understand the issues better. Two decades ago the approach to development was paternalistic and welfare dominated. Over the years this experiment has proved unsuccessful and has taught us that the approach has to be participative if one is genuinely interested in human development.

The 'entry point' to social development in a community is very crucial. The acceptance of the team by the community depends on the initial programme implemented. It is much easier to win the co-operation and enthusiasm of the people if the programme planned is catering to their needs. For instance, it is much easier to get the support of the people and their interest through a health programme than an educational programme like adult literacy, agri. training etc., simply because every man desires to be healthy and he on his own would seek a cure for his illness. A well planned community based health programme, therefore, can play a key role in the process of social development.

This is possible if we do not look at the whole question of development as only 'better health care'. Poor health is just one of the problems of backwardness which has to be seen in relation to the question of poverty, illiteracy and social justice. Unfortuna-

tely most of our health programmes are involved in just promoting better health care and do not link up with the other crucial aspects of a man's life such as gainful employment to be able to have the needed purchasing power to lead a better physical quality of life.

A community health worker is given knowledge on both curative and preventive health care which she or he is supposed to impart to the community. There are instances where the inter-action between the community health worker and the community is only targeted at the women leaving out the children and men. Moreover the topics of discussions remain related to health care and not beyond it to include discussions on social problems like dowry, child-marriages, girl's education, the need to have government health services and agriculture services extended to the community, the need to elect a capable woman leader to the panchayat or Gram Sabha, to question the possibility of improving their income etc. The local team while supporting the CHW should also make an effort to help the community in indentifying and selecting youth leaders (both girls and boys), men and other women leaders who could then from the village team responsible in planning, implementing and monitoring the programmes.

Although the entry point to a community can be through different programmes for the ultimate development of the people the programme must be





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educative i.e. the people must gain some knowledge, must be encouraged to discuss their problems and search answers for them, question their pattern of life and see if it can be better or why is it they are less privileged. Through these discussions and probings it is possible to mobilize the community for social action and quite a few groups are all for such mobilization of rural power. This approach may help the community in getting the desired attention from the hierarchy and even help to solve certain issues but would not have lasting impact because this fight for social justice is difficult to be sustained in a vacuum unless supported by a mass movement in the country. In theory or ideologically the above approach is justified but in reality this is not practicable because of the vastness of the country and population and the ideological differences of the various **social action groups** in the country which makes it all the more difficult to have a common base. Therefore, the practical approach in mobilising the rural poor for their own development would be in helping them to reorganize and improve their economic status. Once they are on a common economic base it is easier to fight the power structure.

This brings us to the question as to how to integrate the health programme with economic activities. While imparting knowledge on better health care and nutrition, discussions should also be aimed at finding out how the families could increase their income to be able to lead a healthy life. I would like to cite here two experiments one in a rural area and the other in a city slum that are being carried out with success.

(a) Development of Garo women

THE east garo hills, being a very hilly area, communication poses a big problem. Most of the villagers have to walk miles down the hills to come to the market to sell their produce. The villages are scattered and isolated, and remain unaffected by modern technology. The Garos are agriculturists by profession. The farming is done by the women excepting for ploughing. They grow only one rainfed crop a year. The most common crops grown are paddy, ginger, tapioca and potatoes. Ginger, tapioca and potatoes are usually sold. The farmers get very little for the sale of these vegetables, simply because there are a handful of business men who control the market. The remaining eight month of the year they are forced to work as labourers or go up the hills and collect fire wood to be sold as well as dig up edible roots for their daily consumption.

Rongjeng in East Garo Hills has a very well run health programme. The sister-in-charge of the health centre who is a Garo herself has been conducting the CRS nutrition education programme through which she has been able to involve and teach 150 illiterate mothers the basics of health care and nutrition. Through the sister's constant interaction with the women she has been able to help them to form an informal co-operative unit. The women decide as to what economic activity must be taken on so as to earn a little more. A year and a half ago they started a small piggery. The pigs were housed in a common place and each woman took her turn in feeding the pigs and cleaning the pen. The piglings are sold and the profits shared equally. The women have also started a savings scheme the money is utilised for some economic activity like purchases of spices, oil and fuel for the pickle making project or in buying more pigs for their piggery. On rotation basis each one donates her land for a year for collective cultivation of either paddy, beans, ginger, tapioca or potatoes.

Last year the group decided to venture into pickle making business, which would not only give them regular employment during the lean months but also fetch them a better price for their produce. Initially they tested the market, found it was saleable and profitable. A funding agency helped the women to construct a **kitchen cum-store room** and to procure the required utensils, containers, oil and spices. The programme is going on satisfactorily, but to conduct the business in a more commercial manner the women need to have the desired knowledge about the pickling processes and also the different varieties of pickles that can be produced (fish, meat pickles, etc.). Knowledge about the varieties of vegetables that can be grown in their area, as well as on fish breeding. Therefore, the women with the help of an expert have planned a long term programme which would give them the required training in pickle business and also simple management skills to run it. The women's group hope that through this gainful employment they would be in a position to lead healthier lives. Care would be taken that everything produced would not go for sale but a part be retained for family consumption. They also visualise to strengthen their co-operative endeavour to an efficient and formal co-operative society.

b) More opportunities for women's employment

It is a slum in Bombay with a population of 50,000. They are rural migrants from all over the

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country with diverse culture and customs. The life of these slum dwellers are as miserable and pathetic as those you find in other cities. The only silver lining in this slum is that the people have organized themselves into a **social action group** for their own community's development. It has been a very slow and painful evolution but the end results are proving advantageous and success.

A number of social welfare agencies are working in this slum. Most of the programmes introduced are classic welfare programmes like medical aid, nutrition programme for under-fives and pregnant mothers, balwadis (creches) and primary schools. In all these programmes the underlining factor has been the **agency's need** to do something. The people are the beneficiaries and are not participants in the programmes. I have not done any evaluation on or a serious study of these programmes to be able to gauge the impact of the same on the people. I am also not sure of the continuity of the programmes once the outside agencies pull out of the area.

In contrast to the above inputs by outsiders the **social action group** of the slum has been concentrating in adult education and economic development. Through daily informal dialogues with the residents on issues relating to slum improvement such as better sewage system, pipe water, municipal health facilities, primary schools, etc. they have been able to get the support of the community in getting these services from the municipality. Over the years the group has realised that more education on one's needs, responsibilities, duties, rights, good health, nutrition, sanitation, clean environment, etc. cannot achieve the desired impact simply because to lead an improved physical quality of life one needs to have the desired purchasing power.

To begin with the **social action group** did a survey to find out the existing skills and occupations within the community. Their findings were very interesting and the group was surprised to learn that they had skilled people such as cobblers, carpenters, tailors, leather and synthetic bag makers, skilled embroiderers and black smiths.

Majority of the women of the slum are under-employed. Some of them work as construction workers, few as vegetable and fruit venders. Both of these jobs do not pay well. In fact their wages do not help them to fetch a decent meal for the whole family. The **social action group** while discussing with

the women as to what could be planned to generate employment the women expressed their desire to cultivate their tailoring skills. (The women are also beneficiaries of Special Nutrition Programme of the State Government).

Through careful planning the women and the Group were able to start a tailoring project. The ladies who were skilled tailors (5) taught the others the techniques of cutting and tailoring. Sewing machines were hire/purchased from loans received at 4% interest from the nationalised banks. The women work at their own homes. They tailor baby suits, children's dresses and under-wears, men's wear and also ladies dresses. The women are also given wages according to the work accomplished. The clothes are sold in the slum itself. The women take turns in selling it. The clothes are peddled in the open on push carts. This venture is proving to be a success. The people are able to buy well tailored garments at very reasonable price, which otherwise they would have to pay exorbitantly in the main bazars and shopping centres. The **social action group** is slowly helping the women's group to form into a co-operative. They are giving them discourses on co-operativism; the women are having individual saving schemes at the post office. Each member takes her responsibility very seriously. They have organized themselves into task groups for various activities such as purchases, distribution, marketing, accounting etc. One of the main reasons for the success of this project is due to the moral support and guidance given by the **social action group**.

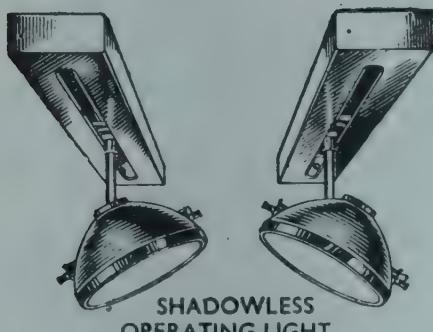
The type of economic programme to be introduced in the area has to be well studied for its viability and feasibility. The ideal economic system would be where the community consumer produces the commodities within the community. The consequences of this system would be

- i) Goods will be produced within the community
- ii) Will be produced by the community thereby generating employment.
- iii) The profits accrued would directly enhance the economic growth of members of the community

The above two projects demonstrate to us that it is not impossible to have people based programmes. The assumption that poor are not bright enough to plan for themselves is not true. What is required of us social workers is to be able to listen to them and elicit their views and plan for their development. It may be true initially they would not come out with

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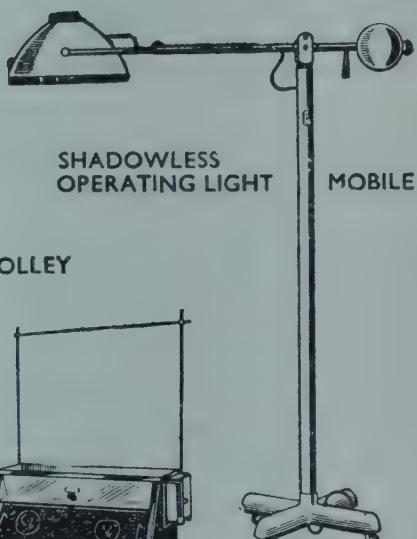
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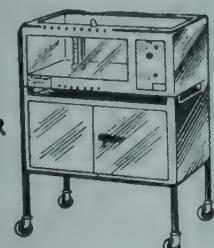


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any answers or plans because they are not sure of the reception of their ideas by us. It may be necessary sometimes for the facilitator to help them to clarify their views and understanding of certain issues; but always we have to be careful to keep a low profile. This is not always easy as we want fast action, but I personally believe the longer the planning process the greater the chances for its success and people's commitment to it. The illustrated economic programmes are a success because it created an economic infrastructure within the community, thus enhancing economic viability of the community. It also helped to enhance employment potentials within the community. The key factor to the success of these projects have been primarily due to its arising out of a need and it being catered by the community itself. In other words the community renders the desired services for its own consumption whereby the profits do not flow out of the community but is circulated within the community for further services. I must also mention here the managerial and community organising skills of the local groups have

helped immensely in the facilitation and initiation of these economic programmes. This goes to prove that we need someone who is professionally trained to help initiate thinking and group action but he or she must always play a low profile so as not to create a sense of dependency among the community. The following Chinese poem could be taken as our philosophy if we genuinely believe in human development :

“Go to the people,
Live among them,
Learn from them,
Love them
Start with what they know,
Build on what they have,
But, of the best leaders,
When the task is accomplished,
The people all rejoice
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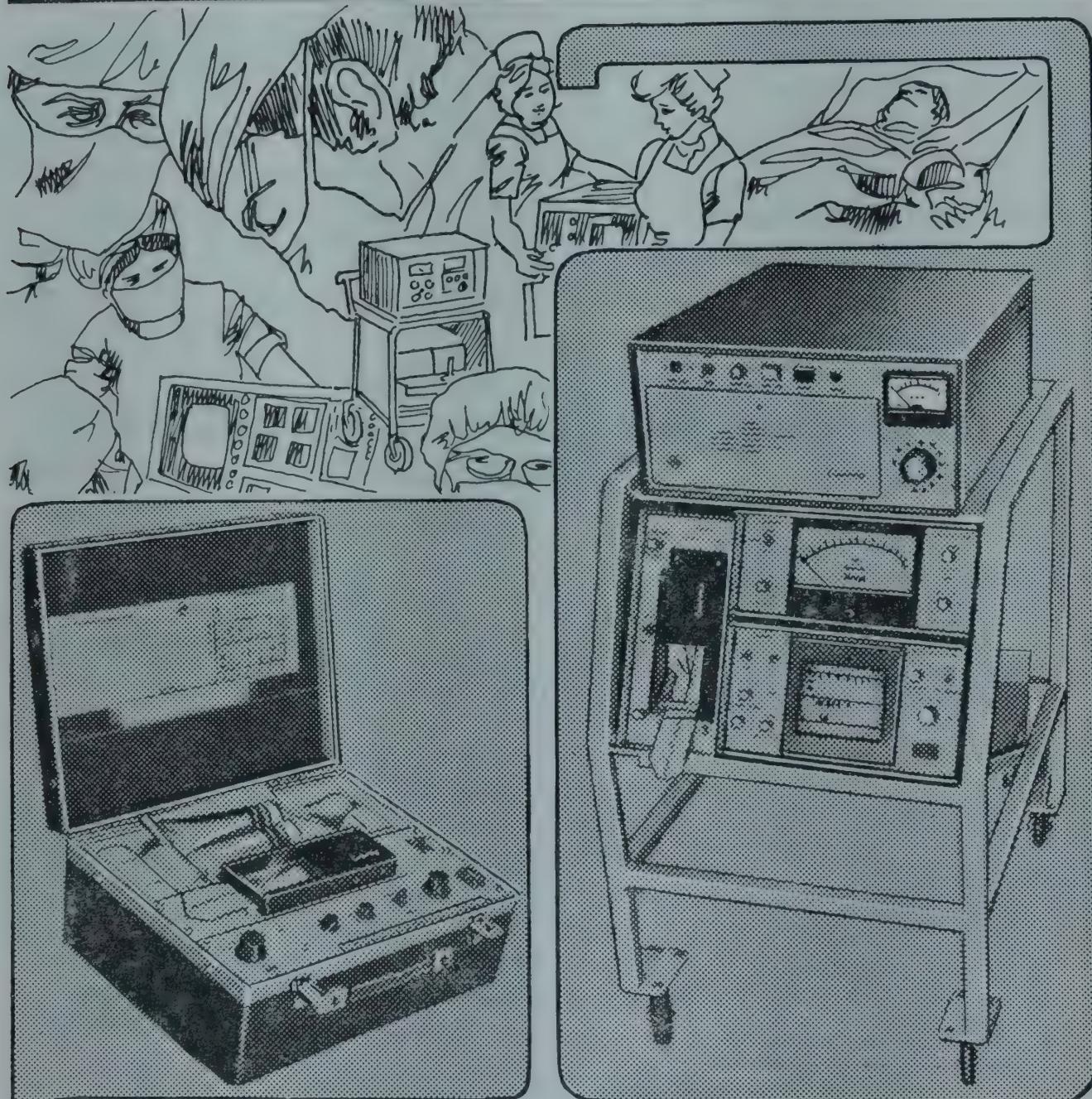
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Spiritual Care of the Sick

By Rev. George Lobo, S.J.

"Healing is the restoration of the whole personality both within itself and in relationship with others"

Total patient care

THE human personality is an whole with the bodily, psychic and spiritual dimensions. A sickness may arise from dysfunction at any level, but affects all levels. Thus a very healthy man may suddenly suffer a multiple fracture through an accident. His psyche too will be badly affected and he is likely to have spiritual problems as well.

Hence real healing is more than treating the fractured limb. It is the restoration of the whole personality, both within itself and in relationship with others. This is all the more true when the disease has its roots in a patient's life and relationships.

Besides sickness is an event in the life of the patient. He will come out of it better or worse, but never the same. It is an opportunity for progressing or regressing. Much will depend upon whether the patient's psychic and spiritual needs are met, whether he is helped to be aware of the existential meaning of the bodily dysfunction and whether he is helped to cope with his deeper problems.

Attending to the spiritual needs of the patient is highly important even from the narrowly medical point of view. Many conditions cannot be cured un-

less there is a 'will to be healed'. There is need for providing or restoring a positive vision of life including its reference to God, the source and end of all existence.

Prayer and healing

THE healing ministry above all consists in sharing the gift of healing with the patient. Hence the healer himself/herself must first experience the healing power of Jesus by a deep life of prayer.

Prayer opens the individual to the personal action of the Spirit of Christ. Thus it is enlightening, strengthening and transforming. It is an inner togetherness with God, and experience of the fact that God is actually at work in and around us.

Prayer deepens the conviction that God is good and hence leads one to manifest His goodness to these who are suffering. It kindles hope amidst so much evil and helps one to be a herald of hope and trust. It is prayer that has sparked the fire of love and devotion in countless religious and lay healers down the centuries. The contemplation of the life and work of Jesus shows how God cares and thus deepens our own desire to care for the sick and the suffering.

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We share with one another whatever gift God gives us during our intimate communion with Him. It makes all the difference to the patient in the corner bed of a hospital ward whether his nurse has prayed or not before she comes on duty, as prayer affects the quality of her life and of all her attitudes towards others.

To pray is to open oneself to God so that one can open oneself to others. Praying for another is to let oneself be filled with the love of God for others, a love that is active and self-sacrificing, a love that is communicative.

So prayer for the sick is not sending a signal to God in the heavens so that He might send down the gift of healing from above to the patient. God is in the one who prays and in the patient. This changes both the healer and the patient; it also deepens the relationship between the two.

Prayer of intercession flows from a personal encounter with God. To meet one who is holiness-in-action draws one into the wholing activity of God as cooperator with Him. Therefore, to pray sincerely is to be involved in a healing ministry because of what God is and does to us. Prayer and care are two different ways of sharing in the same activity of co-operation with a God of compassion.

We are called "to pray always", all through the daily round of work and dedication. A nurse's prayer may well be expressed in an extra gentleness of hands or her smile. But there is need for formal prayer to cultivate the attitude of prayer, of togetherness in God, of allowing God to work in and through us. Activity and service become prayer only by gradual deepening of our spiritual awareness and sensibility through explicit prayer. Such integration is beautifully expressed by the remark of a nurse who said: "For twenty years I used to give an injection with a prayer; now I feel that giving an injection itself is a prayer."

Prayer at a distance is already effective since the human spirit can transcend the limitations of space. (parapsychology has shown that one person can have an effect on another at a distance). But prayer with physical presence is effective in bringing out the confidence of the patient. Vibrations of healing power pass from one to the other more easily. Physical contact like holding the patient's hand or laying on of hands are most reassuring. The latter

also signifies the communication of the divine gift of healing.

However, prayer is not a substitute for psychotherapy or for somatic medical treatment. It acts directly on the spiritual dimension of man, although it also affects the psychic and physical dimensions. Faith and trust are essential for the effectiveness of the prayer. While one should pray with all confidence, it can happen that the Lord does not always will external cure. Even then prayer will be efficacious in bringing peace and comfort.

At times prayer can have a dramatic effect. This is not only true of the times of Christ or the apostles. Besides, the well known events occurring in places like Lourdes, the healing power of prayer has been remarkably manifested in the current charismatic movement in the Church. This is largely due to the strong manifestation of fraternal love and concern which is a sign and medium of the healing power of Jesus.

There is no reason to doubt the efficacy of charismatic prayer for healing at any level. However, too much dramatisation should be avoided. There should be no depreciation of the natural means of healing or medical treatment which too is a gift of the same spirit of Christ. Such neglect at times leads to fatal consequences after an apparent cure or temporary phase of remission of the disease. The Christian should try to achieve a harmonious integration of prayer and medical care.

Visiting the sick

IN the Body of Christ which is the Church, "*If one member suffers, all the members suffer with him*" (*1 Cor 12: 16*). So every Christian should share in the concern and love of Christ and the Church for the sick and show this concern by visiting and comforting them in the Lord.

The sick should be helped to realise that through their faith they are united with Christ in suffering and that with prayer they can sanctify their sickness and draw strength to bear their suffering.

Home visits should not be mere formalities or the reluctant fulfilment of a duty. They should be an expression of genuine love and concern.

The hospital staff, on their part, should realise the importance of the comfort which visits bring

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to the patients. They should not look upon visitors, especially family members as a nuisance to be somehow tolerated. Sickness and hospitalisation dislocate the everyday relationships of the patient with his family members and others. Family tensions may also have had a share in causing or aggravating the condition of the patient and hence it is important that proper facilities be provided for visits. The hospital personnel must know how to enforce necessary regulations with gentleness and to make prudent exceptions whenever called for.

Sacrament of reconciliation

THE sacrament of confession which sick people often receive should not be considered only as a remedy for the soul. Its relation to the whole process of healing should be understood.

Not every sickness is the result of personal sin. Still, in many cases the sense of guilt and alienation resulting from sin produces emotional tensions which may manifest themselves in neurosis or even somatic symptoms. At times, a disease arising from merely organic causes is aggravated by emotional stress due to personal failure to respond to the call of love, which is sin. At other times, the weight of guilt or the sense of alienation from God and neighbour leads to pessimism which prevents the patient from trustfully responding to treatment or from having a warm relationship with the doctor or nurse.

Hence reconciliation is an integral part of the wholing or healing process. It is a complex and continuous activity. It should start by the persons facing up to his responsibilities and admitting his failures before God and his conscience. This should lead to his acknowledging his fault to those whom he has offended, e.g. in the family relations. St. James says : "*Confess your sins to one another that you may be healed.*" (5:16).

The priestly absolution sanctifies and perfects the effort of the penitent towards reconciliation with God, with the neighbour and within oneself. This repentance has 3 stages, contrition, confession and renewal of life.

Genuine sorrow for sin must be clearly distinguished from neurotic or morbid guilt feelings. While this leads to anxiety and even paralysis of the soul, the first opens the way to inner freedom and joy. It

is the conviction of being loved, an experience of God's merciful love and its capacity to transform one's life. Thus the suffering of sickness is transformed into a potentiality for love and sacrifice.

Humble confession before the representative of God and the Church breaks through the crust of self-justification that creates an unrest within oneself and enfolds the person in the solidarity of truth and love. As superfluous defence mechanisms can be dispensed with, energies are released for a new meaningful life.

The real penance that must be performed is the renewal of one's life in the light of the merciful love of God. Accepting the suffering of sickness in union with the passion of Christ gives it a salvific note and helps in redirecting one's attitude towards God and neighbour.

The importance of this process for healing is evident. Hence every convenience should be provided to the patients to profit from this means of peace and joy. Proper privacy should be arranged. The priest should give a patient hearing to what the patients have to say. He should be encouraging rather than stern and legalistic. The whole healing team must promote peace, understanding and reconciliation. At times a counsellor or nurse could say a prayer for pardon and inner liberation. This may not be a sacrament in the full sense, but it has a great religious value and could prepare the way for sacramental absolution at a later moment. Such a prayer could be even more useful for non-Christians or Christians who do not have the practice of confession.

Anointing of the sick

THIS is the special sacrament that blesses and sanctifies the whole process of healing and comforting the sick. It is not meant only for the dying, but rather is to be normally given much earlier when recovery is still possible. It can be given for any serious sickness or as Vatican II says, "in the beginning of the danger of death from sickness or old age."

Sick persons should be encouraged to ask for the sacrament when their condition is serious. It should be given when the patient can take part in the celebration consciously and actively. The legitimate desire of a patient to receive the sacrament should

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certainly be met and every care should be taken to celebrate it meaningfully. (For more details regarding the sacrament, cf. the author's *Current Problems in Medical Ethics*, St. Paul's Publications, 3rd ed., 1980, Ch. 16, D.)

Sacrament of christian communion

THE Holy Eucharist is the centre of the life and worship of the Church. It is the principal way in which we share in the redemptive mystery of Christ. Through its celebration, the individual members of the Church are gathered into the one People of God, every wall of separation and alienation is broken down, and each one is called to go out to others in a spirit of service and sacrifice. The Eucharist then is the summit of the Church's healing activity,

The patients in the hospital should be provided with every facility to take part in the Eucharistic celebration. With the permission of the bishop, the celebration may be had in the homes of the sick and the aged.

Sick person must be offered the opportunity of receiving Holy Communion frequently. The relation of the sacrament to the Eucharistic celebration of the paschal mystery in the Mass must be emphasised so that the sick person is united with the redemptive suffering and glory of Christ. The sacrament must be understood, not only as a comforting union with Christ, but also as a sign and means of communion with others so that the spirit of union may act as a healing power in the sick people.

Holy Viaticum is the real sacrament of the dying. Christian tradition stresses the importance of receiving the Eucharistic Body and Blood of Christ at the moment of death as the spiritual food for the last momentous journey, and pledge of the final saving encounter with the Lord.

Counselling the sick

WE have already noted that sickness is often a symptom of an unresolved psychic problem and that even somatic illness brings with it various psychological tensions. Hence the integral process of restoring or healing the person within himself and in relation to society calls for the help needed to resolve his psychic problems.

This is done by informal and formal counselling. The first is an understanding and empathetic attitude

of the members of the healing team who pay attention to the human problems of the patient in all their contacts with him. The nurse especially can do a lot by just listening to the patient when he needs someone to whom he can express his feelings and from whom he can experience some understanding and acceptance.

Formal counselling is the same but conducted by a trained person with a clear goal and approach. The principal role of the counsellor is to create the atmosphere in which the client himself can work out his own understanding and cope with his problems. The interpersonal relationship between the counsellor and the client is mainly characterised by trust which brings emotional security.

There are some crisis situations in the course of the sickness itself that specially call for counselling e.g., choice of therapy, an operation, approach of death. Several types of illness bring with them characteristic stresses and tensions which need to be handled delicately by the hospital staff in general, and in aggravated cases by specialised counsellors.

In dealing with the sick it is more important to know what manner of person has the disease than what the disease he has. Sick people variously tend to be ashamed and secretive about their ailment. Many are inclined to complain and find a scapegoat in one close at hand. Some withdraw into unresponsive apathy. One of the most common distresses in sickness is fear or anxiety. Quite a few patients experience rejection, loneliness, and even despair accompanied by even death wish. Patients as a rule have a lot of unmet needs which need to be attended to. While the whole healing team should meet them, the counsellor has a special role in the matter.

'Pastoral Counselling' more explicitly handles the problems of faith and morality and hence gives or restores a profound direction to life. The pastoral counsellor need not necessarily be a priest, but he or she presents himself or herself as a brother or sister in Christ in deep human and Christian solidarity.

Still, the priest chaplain who is specially deputed to bring the healing power of grace to the sick, is particularly suited to exercise the role of pastoral counsellor, provided he has necessary gifts and is adequately trained for the job.

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Conclusion

Every patient has the right to an adequate care.

This includes proper spiritual care. The need for it becomes clear if we have a holistic view of sickness and healing. Though much is being done, the spiritual needs of the patient are not taken care of as they should be. Hence every effort should be made to fill this lack by more diligence on the part of the hospital management and staff. Besides, every member of the healing team contributing his or her share, there is need of having specially trained people to handle the spiritual aspect of patient care.



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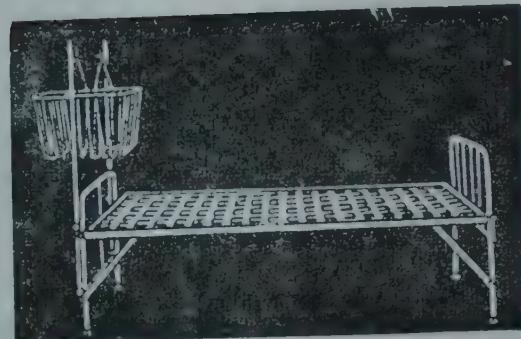
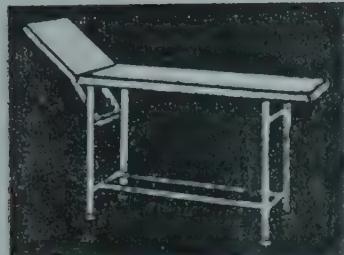
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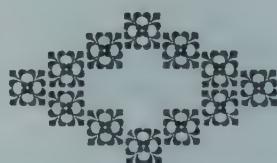
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WHOLISTIC CLINICS

By Dr. Granger Westberg

Roots of illness

ONE of the first things I noticed in my work as a chaplain was how many patients were telling me about something they had *lost*, something which had gone out of their lives in the 6 months to 2 years prior to their hospitalization. Sometimes it was the death of a loved one, some had to move away from places in which they had put down roots, and some had been forced to retire. Other losses experienced were of reputation, marriage, contacts with people, and of children who had either turned their backs on their parents or simply grown up and away from them.

Another factor apparently linked to illness is "*stress*"—a word first used extensively in his work by Dr. Hans Solye of Montreal in the 50s, and which has now become rather an "*in*" concept in Western medical circles, as well as a very useful one. Yet another such factor is *life changes*. The record cards I kept on patients showed clearly that these elements—grief, loss, stress and life changes—were present in the lives of, by far, the largest group of my patients.

I expressed my thoughts about the importance of these factors in illness to the hospital staff who were not overly impressed. But, about a year later, the nursing school staff of another hospital where I had also spoken of my findings, introduced a question on loss into a questionnaire administered to 300 new patients, and found that 30% of these

were immediately able to point to certain things which had caused them grief or a sense of loss in the 2 years prior to their hospitalization.

I would suggest that, if one in every 3 patients in a hospital is suffering from a certain condition, be it a brain tumour or grief and a sense of loss, it is essential that the hospital engages a full-time specialist in that field. I am suggesting that every doctor who suspects that his patient is in hospital because of a grief situation should immediately call in the "grief specialist", i. e. the pastoral counsellor. Unfortunately, I think that it is difficult to convince doctors that a full-time grief specialist is worth the hospital's time and money. And this brings me to taking a look at the health care situation in America in particular, and the West in general.

Groups of general practitioners to whom I have spoken over the past few years generally agree that 50-75% of their patients—i. e., patients in primary and not tertiary care—are more in need of spiritual than of medical care, and that the problem they face are in the areas I have just describe, i.e. loss, stress and life changes. One doctor I spoke to recently admitted that he was very cautious *not* to ask his patients how things were going with them because "*then I get a whole lot of words; words that I don't know what to do with.*"

Most illnesses come gradually. It is as if the body is showing what is going on in the person's heart, in

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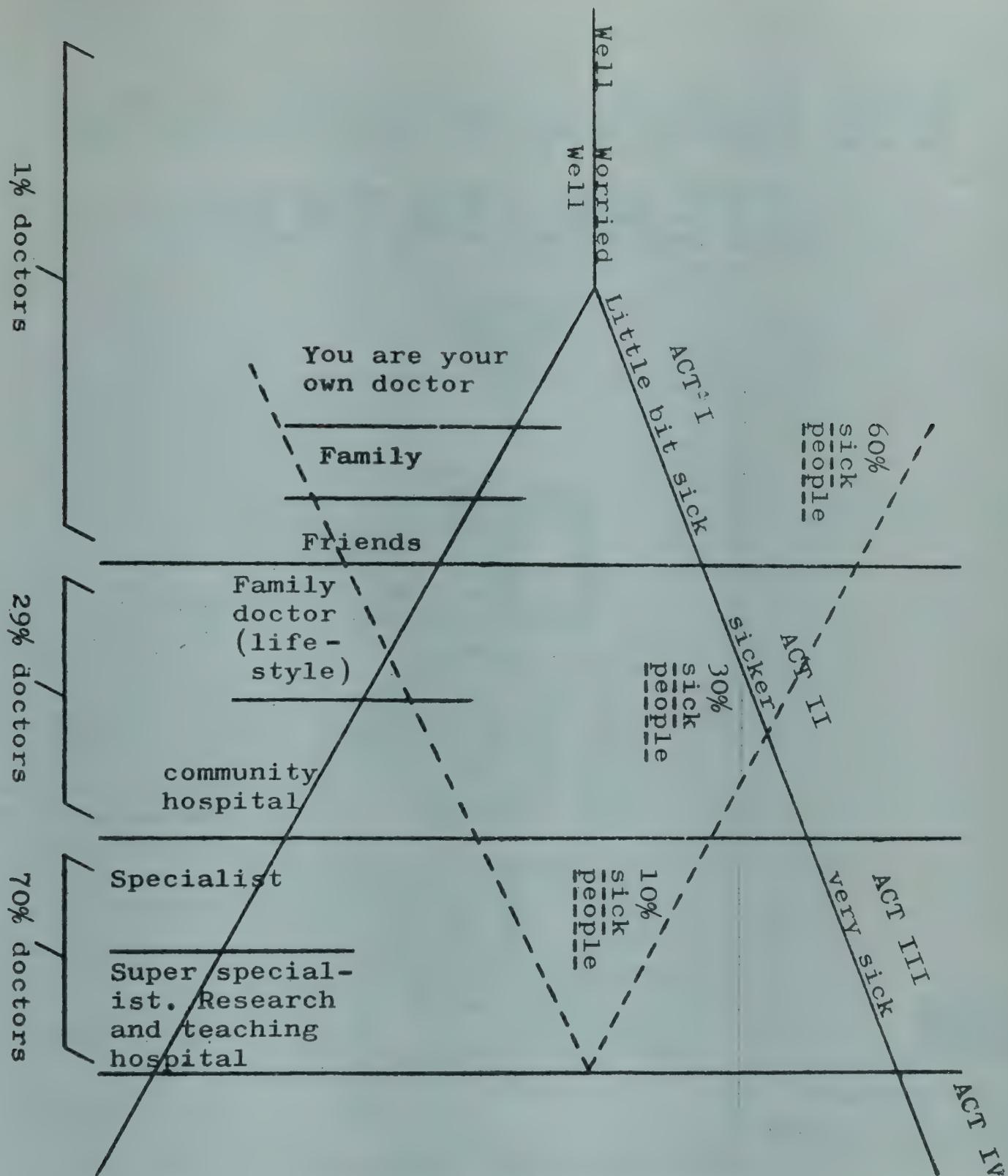
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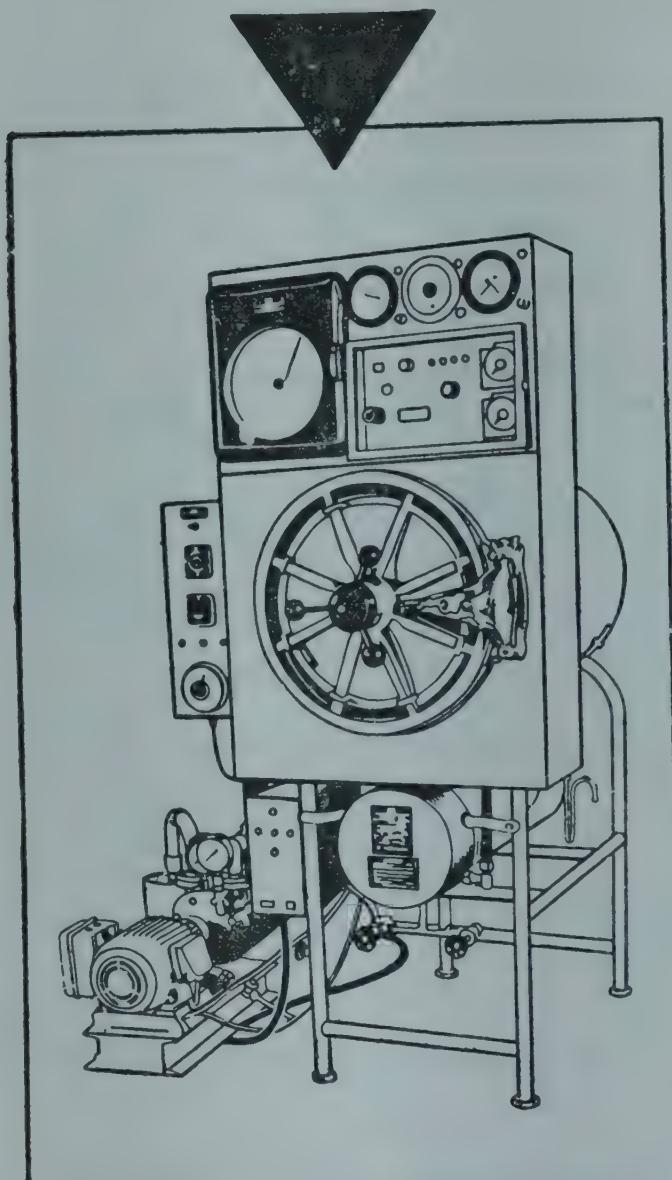


gradual stages, rather like acts in a play. I have tried to illustrate this process of the body's gradual revelation, through stages of illness, of the inner problems of the person. (see diagram).

In the diagram, I have divided the illness drama into 3 acts: "little bit sick", "sicker" and "really sick". The unbroken line shape shows that illness comes on gradually. Before entering the drama proper, however, there are "well" and "worried well" stages. Approximately 60% of sick people in the

U.S. in Act I, 30% in Act II, and 10% in Act III. As you or I enter the drama, at the beginning of Act I, we normally (99% of the time) act as our own doctors, making diagnoses and decisions about our own bodies, and deciding on a treatment plan. If our diagnosis was correct and we follow our own good advice, we soon begin to feel well again. If not, and we feel sicker, we move into the middle of Act I. Now, our families begin to notice and become the doctors. "George, you've just got to slow down. If you don't, you are going to get sick." If we don't heed

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this advice, we get sicker. Now, we are at the end of Act I and some friends begin to notice our condition. "Hey, George, when did you last have a physical check-up? You haven't been looking well for the last couple of weeks. I'm worried about you." "The friend's intervention is often effective and we get well again.

It is interesting to note that there are practically no doctors in Act I. Only a very tiny proportion of doctors in the US are devoted to preventive medicine. It is just people helping people. Doctors do not go into this no-man's- land because they have been trained to take care of sick people. After 35 years, I have given up trying to persuade them to do so, and I now realize that there are other people who can do this job better.

The first group of such people are *nurses*. Nurses have a natural ability in this area due to their interest in health education and preventive medicine. The second group are people in the social sciences, e.g. *social workers and school teachers*. The third group are the *clergy* and an increasing number of clergy in the US have had clinical pastoral training. I think that at least one third of all pastors in the US are interested in, and have a gift for, pastoral care and counselling. They need to be drawn out. The fourth group are *lay people*. This group, with training, can be of immense value in Act I.

Now to get back to our diagram, if we do not listen to ourselves, our families or our friends and do not take care of ourselves, we will get sicker and enter Act II. Here, we feel sufficiently uncomfortable to visit our family doctors. Today, in the US, the family doctor may want to ask us questions about our life-styles, believing that there is something there which is making us sick. Many doctors who previously prescribed medication automatically have changed their way of treatment, which has not been easy. Many patients, however, respond negatively to such probing and demand medication. If the family doctor is right in his diagnosis and gets a positive response from us and if we follow his advice, then we get better. If this does not happen and we come home with boxes of pills, we might find ourselves coming back again and again, getting gradually sicker. At this point, our family doctor suggests a check-up at the community hospital. Most of us do not ever get sicker than this and are able to be taken care of by our family doctor at a community hospital. But, suppose we do not get well after the stay in hospital? Then our family doctor recommends a specialist.

Here, we are entering Act III of the drama. Many specialists are bothered by the fact that they see the patient only at this stage and are wondering whether they ought not to be involved in Act II already. One of them puts it very vividly : "I feel like I am going to see a play...and I get there very late. I slip into my chair and the play has already gone into the third act. I watch the stage and listen to the players and try to understand what is going on here. I have a difficult time figuring it out because I didn't see acts I and II." We go to the specialist and, in most cases, we are cured. But, in some cases, we do not get any better and, finally, the specialist suggests that we go to a teaching and research hospital, often far from our homes. Here, we are sometimes cured but, being realistic, not always.

One day, as I was describing this drama to a group of doctors, one suggested a different kind of wedge. As pointed out, and as is illustrated by the broken line wedge in the diagram, although approximately 60% of sick people in the US are in Act I, less than 1% of all doctors work there. They are the doctors who work in public health. About 29% of doctors decide to work in Act II, looking after medium sick people, where approximately 30% of all sick people are. And, although only 10% of sick people are in Act III, this is where the glamour, the money, the big hospitals, the TV programmes are, and 70% of all the doctors work! In addition, as another member of this group of doctors—a dean in medical school—pointed out it is in the teaching and research hospitals, into which only 0.01% of the sick people are admitted, that young people are taught by super-specialists to be doctors. They see only patients who are very, very sick, who represent only 0.01% of the sick people in the country, and they make their plans for their future careers based on this exposure. As a result, they decide to stay in Act III and become specialists because this represents "*the top*" of medicine. Fortunately, this trend is beginning to be reversed. In more than half the medical schools in the US, medical students in their first and second years are being sent out into community hospitals. Here, they are able to meet ordinary patients with ordinary doctors, dealing with the kinds of problems that many more graduating students are now going in to family practice residency programmes. And the government is giving money to medical schools which will start such programmes and is taking money away from other specialities.

Assuming that we need only 30% of our doctors to work with the 10% of very sick people in Act III,

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and 65% to deal with the medium sick people in Act II, that leaves 5% of doctors over for Act I, where 60% of sick people are located. But, as I pointed out earlier, there are other people who can provide the care needed in Act I more effectively than doctors. And there is no point criticizing doctors who are interested in practising with sick people for not wanting to work in this Act. We would do better to praise them for what they are doing in Acts II and III.

In 1952, I was invited to the University of Chicago Medical School. There, we started a weekly religion/medicine case conference between a doctor, a minister and a nurse who presented a case. We attempted to approach the case from the physical, mental and spiritual angles. Although it was very difficult to put into practice, and always easier to talk about the medical than the spiritual dimensions of a case, we nevertheless found the exercise a very worthwhile one. But, after 10 years at the medical school, listening over and over again to stories like the one I will tell you in a moment, I began to question the usefulness of spending the rest of my life in a teaching and research hospital, dealing only with people at the very end of Act III. The story is one told me by a man who was about to have half of his stomach removed. I asked him when he had started to have stomach troubles and he said : "I can almost pinpoint it to 10 years ago when our son got into trouble with the law—serious trouble. He was put into jail. That had never happened in our family before. Both my wife and I became ill. And I developed severe abdominal pains which were bad enough for me to go to the doctor. He gave me some medication which helped until the time of the trial. At that time, I became more upset and went back and got some more medication. After the trial, our son had to stay in jail and I just seemed to have one bad thing after another happen to me. I finally developed ulcers which I have had for 10 years. Now as they have been getting worse, the doctors say that I have to have half of my stomach removed."

After hearing this kind of story repeatedly, I began to think : "Here I am—this man's hospital chaplain. I have only a day or two in which to do anything for him. I can be with the family during surgery and I can be with him for a short while afterwards. Then he will be gone and that will be the end of my ministry. No chance to get to him in depth. What if, instead of meeting this man in hospital at this point, I had been in his doctor's

office 10 years before when he came in for the first time ? I would have heard his story at the same time as the doctor and, after the doctor had written his prescription, I would have invited him to my office, I would have said : 'Tell me more. I know your heart is breaking for what has happened to your son.' And hopefully, he would have felt fare to express himself, knowing that, otherwise, it would tear him apart inside. Then, because I would see the situation as an emergency, I would invite him back the next day with his wife, and the three of us would talk and talk and probably cry a bit and then talk some more. After that, as pastor, I would go down to the jail and visit his son and try to understand what had gone wrong. I could try and bring about some kind of communication between them. And, over the next several months, the doctor and I would minister to that entire family, not just to a stomach. And may be that man would not have come in to have half his stomach removed 10 years later.

Getting started

I became so concerned about this possibility and convinced that I, as a minister, and we, as Christians, have the ability to keep people well, that I moved out of the medical setting and ended up with Prof. Dr. Karl Hertz (now Director of the Ecumenical Institute, Bossey near Geneva) at the Hanna School of Theology at Wittenberg University in Ohio as a professor of practical theology. Then I had to prove that I was practical, so I became a pastor in a low-income neighbourhood in Springfield where there was a very high incidence of ill health. We set up a doctor's office in the church and were helped by my seminary students and volunteers, including some ministers, from the various other churches in the neighbourhood. The idea of setting up the doctor's office in a church was based on the belief that the location of a doctor's office should promote not only good medical care, but also good counselling care and good learning opportunities for the patients. For a doctor *not* to teach his patients how to stay well is pretty ridiculous.

So, after announcing the opening of our doctor's office in the schools and to the people of the neighbourhood, we waited for patients. We waited and waited for 3 successive weeks and nobody came. We found out afterwards that people thought we would try to hit them over the head with religion. The fourth week, as we were about to give up, a patient appeared. She was a woman who worked in a saloon

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near the church, a pretty tough-looking character who expressed herself very clearly and forcefully as well. Although she had been feeling very sick, she did not have a temperature when she came in. But she accepted the nurse's invitation to stay a while and talk. She talked quite freely and said that she had no time for pastors who, she thought, were a bunch of hypocrites who talked and talked—a lot of "yackity-yack"—or for the church which she did not see as contributing anything valuable to the community. In fact, no one from the church had ever *touched* her. After a while, she began to feel that something different was happening in the situation in which she now found herself. For the first time, someone was touching her with love, interest and concern. And she began to ask: "Why are you doing this for me?"

The next week, a lot of patients came in who were her friends. And so, the clinic began. We asked for, and got, the warmest people from the local parishes as volunteers and gave them a course on how to listen to and talk to people. The ladies working in our reception area explained to new patients that they would see not only a doctor and a nurse, but also a pastor who would take their social history and get acquainted with them. Most of the people who came in accepted this, but some objected. Then it was the job of the ladies at the reception to point out that there was no extra cost involved and to introduce the person to one of the young seminary students, which often made them change their minds. Some of the people who had been most reluctant to talk to a minister at first were those who, months or years later, told us that this had been the first time in their lives that anyone had ever listened to them in depth. The result was that usually they didn't want to stop talking after 5 or 10 minutes, but went on and on. Within a year, many of these same people would come in and say: "*I'm not sure I need to see the doctor, but I would like to see a minister!*" I think it is significant that, within one year, people could see that illness is not strictly a physical problem but a wholistic one.

About 18 months later, I was describing our experience to an enthusiastic group of students and faculty at the Howard Medical School in Washington, an essentially black school. They suggested that this kind of clinic should not be confined to poor neighbourhoods. That would seem to show that it was a poor man's medicine, while rich people demanded, and got, unadulterated scientific medical care. This group suggested that we should try to set

up a clinic in a middle or even an upper-income neighbourhood, to prove that people in these neighbourhoods would not only go to, but even pay for, this kind of care.

The idea excited me and, having joined the staff of the State University of Illinois Department of Preventive Medicine, I finally was able to put it into practice in a rich neighbourhood of Chicago called Hinsdale. This was an area with more doctors per square mile than any other suburb in Chicago. As I explained to the Congregational Church committee where we planned to set up the clinic: "*If I can get rich people to come to a church basement to see a doctor because there is a pastor on the staff and they deal wholistically with people, than I have proved the need for such an approach and will be able to apply it anywhere in the US.*" It took a long time for people to come to the Hinsdale clinic. The first to come were nurses, then social workers and then school teachers. All talked about the good care they were getting in the wholistic clinic and, finally, we had more people than we could handle.

So we went to a Methodist church in a middle-income neighbourhood in another part of Chicago, and that clinic got going very fast indeed. The next one was in a rural area about 70 miles outside Chicago. A young woman doctor who had been coming into Hinsdale to gather insights on how to deal with her patients, whose illnesses, she felt, were mostly caused by problems of the human spirit, felt so reassured by being able to work with a pastor and so impressed by what this approach was accomplishing, that she was inspired to attempt to start a similar clinic in her own area. The ministers of three different churches in the area volunteered to have the doctor's office in their church, and lay people from the churches built the clinic.

Nowadays, when we want to open centres in a city or region, we find it best to start in a high-income neighbourhood before going into a low-income one, since if we start on the low-income side of town, people on the rich side feel that kind of care is only for poor people. Another feature of the centres in the last 5 years or so is that they relate to medical education and provide experience to residents in family practice. Some young residents, as a result, are saying they would like to work full time in a wholistic health centre.

The health care team—how it works

Another development in our centres in recent years relates to the form of the patient's first con-

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sultation. When we first started, the pastor saw the patient first, then took him to the doctor and explained what he thought would be useful for the doctor to know. Many doctors were amazed at the amount of personal and pertinent information gleaned by the pastor. They wanted to sit in on that first session and suggested that the nurse join in too. This developed into a different approach to communicating with the patient which we call the *process of engagement*. If a patient calls to complain of a specific physical ailment, we tell him to come in immediately and we attend to him then. But if he simply asks to come to the centre for an appointment, we send him a little brochure explaining the purpose of his first visit and asking him to complete a questionnaire list of all the important events in his life over the past 2-3 years, particularly those which reflect important changes, good and bad. Listed are changes in relationships, in residence, in habits and activities, dominant feelings, outstanding achievements, physical symptoms which concern them, strengths and weaknesses, goals and the kind of help needed to achieve them. The brochure explains that "our intention in your first visit is to engage you in an individualized plan for becoming and staying healthy. We believe that being healthy is more than having a body that works well. It is feeling good about yourself, dealing creatively with the people and situations around you and growing spiritually toward a sense of wholeness. We call our initial meeting a *health planning conference*. You will meet with a health care team consisting of a physician, a nurse and director of counselling. We will talk together about which of our professional

skills would be most helpful to you and arrive at a plan for working together. We recognize that the final decisions about the plan are up to you. The best we can do is to make recommendations and offer our services. We have found that people appreciate and benefit from the opportunity to reflect on all of their concerns prior to the initial conference. This pamphlet is offered as a tool to help focus your reflections before the planning conference. Please bring it with you."

So now, when the patient arrives at the centre, he or she is met by a volunteer lay person who has taken special training. He is introduced to one of the nurses, who sits down with the patient and gets acquainted with him. She becomes the patient's advocate and makes sure that he is being *heard* by the doctor and minister. She takes the patient to meet them and the conference begins with the minister as moderator. We don't want the patients to get the impression that the minister will be referred to only if the doctor feels it is necessary. Thus, the minister begins by asking the patient to talk about himself. The nurse acts as a catalyst to blend the religious and medical elements of the conference together. Although we thought it might be a problem it seems that very few people mind confronting three professional people at once in this way. In fact, it makes it easier because if you don't get along with one of the three, you have two others to relate to. And people feel free to talk about spiritual problems as well as medical ones because of the pastor's presence, and about family problems because of the nurse's presence.

• • • • •

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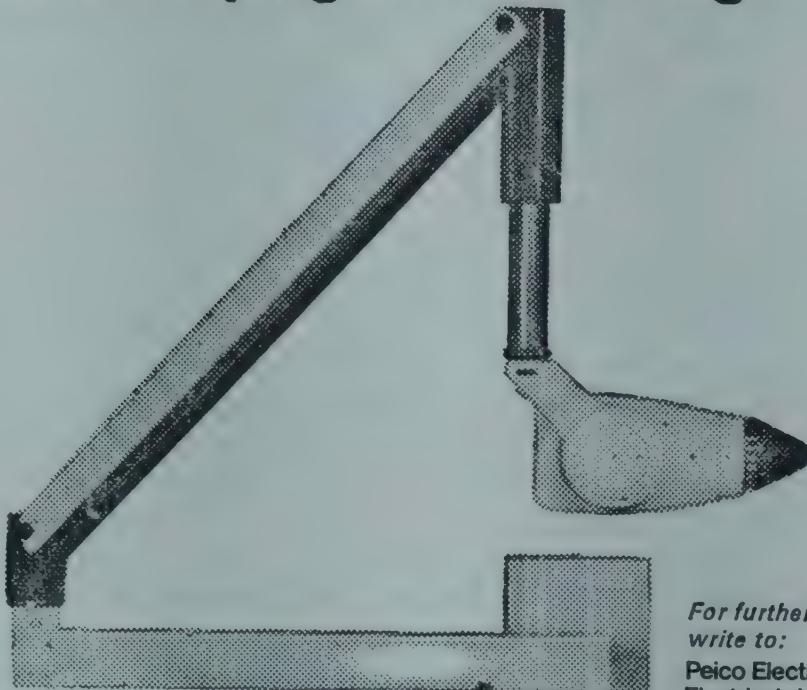
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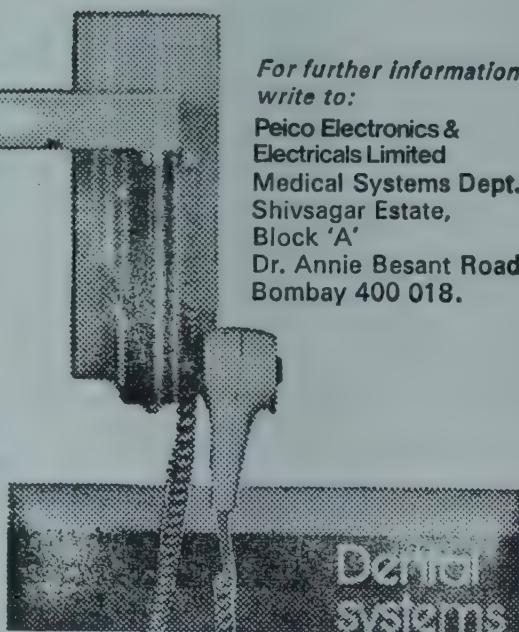
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HEALTH FOR ONE MILLION PROJECT, TRIVANDRUM

a dream came true a thousand workers grew

By Fr. Lawrence J. Thottam and Sr. Eymard

Health for one million programme of the Trivandrum Archdiocese has achieved the target in six years. It was a 'dream' of reaching one million people and training 1000 village level workers.



"HEALTH FOR THE MILLIONS" was the theme of the National Hospital Convention of the Catholic Hospital Association of India in the year 1973. The thought-wave generated from here inspired several participants to enter into the field of Community Health. This idea was later nurtured very much by the Voluntary Health Association of India.

A group of people in Trivandrum enthused by this concept discussed and shared this idea with their co-workers and friends. By the end of the year 1974 they arrived at some concrete plans and proposals.

They decided to plan for the better health and development of one million people. Thus started the "Health for a Million" Programme of Trivandrum.

During the year 1975 several experiments were made, objectives clarified and the programme was defined as follows :

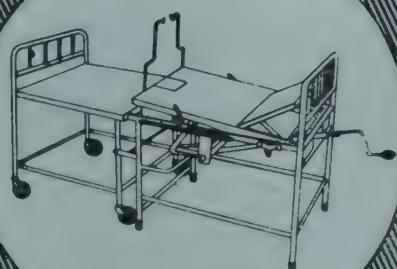
"Health For A Million" is a philosophy of Health Based Community Development/lived by people of a community/consisting of about 1000 people in the Micro-level/under a Macro-plan covering one million people.

As a continuation and clarification of this philosophy the following **Guiding Principles** were established :-

1. **Health care** is more important than mere disease cure.
2. Health can be maintained only in the context of **Total Human Development**.
3. As development is self-growth or growth from within, **Self-Help and Self-Sustained Programmes** are the most important. Outside assistance could be of use only to the extent of bringing people together, co-ordinating local efforts and encouraging local leadership.

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4. Community Decision is more meaningful than mere community participation. This would mean working with **people** rather than working **for them**.
5. In conducting programmes, **local resources** in the form of personnel, finance, Government facilities, and social structures irrespective of any religious affiliation, caste distinction or political bias, are to be utilised to the maximum.
6. In implementing the programme, principles of **appropriate technology** would be followed.
7. In educating people on Health and Development **Formal** as well as **Non-Formal Methods** of education are to be adopted.

As a **strategy of approach** it was planned that in the micro level groups of 200 families consisting of approximately 1000 people irrespective of caste or creed distinction should be surveyed and registered as



one Health and Development unit (H.D. unit). These people are to be helped to grow into one community and function as one unit. Any cultural centre, school reading room, temple, etc. could serve as a centre for this H.D. unit.

Similar one thousand units of 1000 people each would make this programme of one million people. The programme was to have two phases — The training period and the activities period.



First phase (training period) : The period upto the end of 1980 was to be the training period. During this period the plan was to :

- a. train 1000 village level volunteer workers. From among them 100 are to be trained to be promoters of the programme; 10 from these promoters are to be trained into organisers of the programme.
- b. Each village level worker is to be responsible for 200 families of about 1000 people; and find 20 **mother leaders** representing 10 families each.
- c. Conduct such activities as would help for the training of the workers as well as the people.

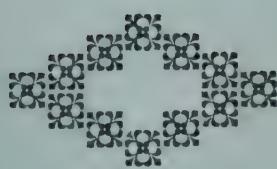
Second phase (activities period)

- a. **People would organise their own developmental activities.**

Possible tenfold activities are :-

- i) Education on health and development.
- ii) Nutrition programme.
- iii) Juvenile guidance.
- iv) Special care for children under five years.
- v) Maternity care.
- vi) Family planning through responsible parenthood.
- vii) Socio-economic development.

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- viii) Environmental sanitation.
- ix) Disease control and healing the sick.
- x) Rehabilitation of the disabled and under privileged.

Plans accomplished

During the course of the past six years the dream of reaching one million people and training 1000 village level workers has been realised.

Today you can see over 1000 village-level workers instructing groups of about 20 mother leader each at least once every fortnight in 1000 centres in the districts of Trivandrum, Quilon, Alleppey and Kanyakumari.

These mother leaders after attending their classes communicate what they learned to at least 10 other



Chief organisers and coordinator of "health for a million", Trivandrum.

mothers around in a most non-formal way — near the well, on the way to market, etc.

The village-level workers besides taking this fortnightly class, regularly visit the 200 families and wind the people into a community.

They help the villagers to organise associations for women and youth and encourage small savings.

They maintain the health records of children and women of the village.

The best of every ten village level workers is considered as promoter of the programme. There are such 100 promoters among the 1000 workers.

The health promoters collect reports from the health workers once in every month and guide them on the topics to be taught during the following month. The best of every ten promoters is considered as an organiser of the programme. There are ten such organisers.

The health organisers meet the health promoters once in every month and get their reports and communicate to them the topics for the following month. These organisers are united under one coordinator.

The co-ordinator meets the organisers once in every month, collects the report and plans together with them the programme for the ensuing month.

Thus the 100 workers function under a self-made 3 tier system under a coordinator. Within a month all communications reach from the co-ordinator to the worker and the feed back from the worker to the co-ordinator reaches also within the same period.

This year 1980 marks the end of the first phase and the beginning of the 2nd phase. It is proposed to hold a convention of all the trained personnel in Trivandrum on December 2, 1980. □

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Anesthesia Training for Nurses

By Mary K. MC Nabb BA CRNA

A Declaration of Rights for Nurses' training in administration of anesthesia says :

- 1. The right to help others in need.**
- 2. The right to develop and utilize talents and abilities as citizens of India.**
- 3. The right to receive adequate training at nominal cost from those who are capable of teaching and who have higher education in the field of anesthesia.**
- 4. The right to provide adequate anesthesia services at lower cost to the health care system.**
- 5. The right to assume the responsibility for administering an anesthesia as delegated by a properly qualified doctor, surgeon or MBBS DA, if in charge of the department.**



Nurses have been asked and are still being asked to manage patients under anesthesia or to give full anesthesia under the direction of the surgeon in the absence of other trained personnel. Many smaller hospitals have a limited number of medical staff and they are also often untrained in anesthesia or have other hospital patient responsibilities. Consequently if nurses are asked to take on these anesthesia duties it is only correct that they should be able to avail themselves of some systematic training to meet their needs adequately.

Till 1976 the existing training facilities for nurses giving anesthesia included, so far as I know, either three month or six month or one year practical programmes, depending upon varying viewpoints of what was then considered to be adequate training in anesthesia for nurses. The Voluntary Health Association of India (VHAI) designed a course plan in anesthesia in 1976 after consultation with a number of persons including as broad as possible a representation of interested parties. These persons included medical superintendents, surgeons, nurses who had training in anesthesia, nurses and doctors who were training nurses in anesthesia, nurses without training in anesthesia who were called upon to give anesthesia, hospital administrators, and doctors who had specialised in anesthesia of the categories MBBS, DA and MDDA. The following ideas were elicited :

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anesthesia, and related topics.

2. Adequate amount of anesthesia practice in various categories or types of anesthesia equipment as well as types of surgical cases.
3. Plenty of practice in anesthesia so that the finished candidate could function with some feeling of confidence.
4. A system of evaluation of performance as the main basis for successful completion of the first year.
5. A recommendation after actual performance of duties in sponsoring body so that goals of training are accomplished for the sponsoring body also.
6. Sponsored candidates only are taken.
7. Utilization of already trained anesthesia staff for teaching in already constructed institutions in a multicentred coordinated programme.
8. A minimum two year programme was advised by MBBS DA and MDDA personnel.

Presently the prerequisites for the course of study are:

1. True copy of School Leaving Certificate Attested.
2. True copy of Nurses Registration Certificate (attested)
3. Two letters of recommendation from responsible persons not related to the candidate.
4. Only sponsored students will be accepted.
5. English writing and speaking.
6. Student should preferably have some experience as a graduate nurse in operation theatre and or have a Midwifery certificate.

The following plan was then formulated :

3 months introductory theory and sciences with emphasis on application to anesthesia.

12 months supervised practice in an assigned hospital with trained supervisors in anesthesia. Monthly summary sheets with actual cases categorized for assessing progress and experience to be sent to a coordinator.

12 months practice in sponsoring body's hospital or another hospital if the selected hospital is approved for practice.

The student completes a 27 month period before certificate is awarded. However, only 15 months need be spent outside the sponsoring body. The cost of the course of study is as follows :

$$\text{Rs. 250.00 per month} \times 15 \text{ months} = \text{Rs. 3750.00}$$

as a breakdown of expenses :

Rs. 100.00 per month for food

Rs. 100.00 per month for tuition

Rs. 50.00 per month for minor medical expenses, electricity, room, etc.

Objectives of a study programme for nurses in anesthesia :

1. To prepare the nurse to administer anesthesia basic to the general role of administration of anesthesia.
 - a. Anesthetic volatile agents and gases : Halothane, Ether, Trilene and nitrous oxide and oxygen.
 - b. Anesthesia systems: Drawover, open and semiopen system and continuous flow machines with semiclosed systems with and without carbon dioxide absorption.
 - c. To perform endotracheal intubation for adult or child.
 - d. To perform and manage regional block techniques.
 - e. To utilize properly muscle relaxants, narcotics tranquilizers, hypnotics and other drugs related to anesthesia as a part of the anesthesia administration. To have a basic understanding of drug actions and reactions and to know when to anticipate their occurrence in the anesthesia process and how to allay occurrence, if possible.
2. To develop good technique in observing and recording of vital signs of the patient under anesthesia. To be able to recognize the patient's progress through the stages of anesthesia, recognize conditions of shock, bronchospasm, laryngospasm, blood loss, partial and complete airway obstruction, carbon-dioxide retention, cardiac and respiratory arrest, and to know what is recommended care of the patient in such occurrences. To understand enough about how these processes occur to anticipate problems and conduct a smooth anesthesia.

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3. To know what is adequate equipment for an anesthesia department and how to maintain this equipment in good working order.
4. To develop an understanding of the importance of proper preoperative assessment and postoperative anesthetic care of the patient.
 - a. To learn to establish a good rapport with the patient beneficial to the healing process.
 - b. To develop enough confidence in administration of anesthesia and to perform well enough that the supervisors also have confidence in the nurse.

There are some additional advantages in training nurses in anesthesia and one of these is that the trained graduate may fulfill a multipurpose role. If anesthesia services are not needed every day in the week, other nursing related duties may be carried out. In looking over the certificate holders of the Voluntary Health Association of India's nurse anesthesia course, the following are some of the ways that nurses are being utilized IN ADDITION to anesthesia services in smaller institutions :

1. O.T. supervisor
2. Matron
3. X-ray and laboratory technician (with recognized certificates).
4. Surgical ward nursing
5. Intensive care and post operative observation units.
6. Public health nurse in nearby village.

Some of the present certificate holders are employed as nurse anesthesia staff members in the anesthesia department of large institutions with in-charge of MBBS DA or MDDA qualification. This is a practice which can enable the institution to provide adequate anesthesia services at lower cost to the patient. To the hospitals where this type of programme has been carried out, the cooperative relationships for working as a team may also be listed as a positive attribute.

All nurses trained in anesthesia cannot always work under an MBBS DA qualified doctor. There are simply not enough doctors with this qualification and even in countries with greater financial resources, optimum advantage to the health care system is realized through training of nurses in anesthesia. Nurses are trained under government encou-

raged or recognized programmes in anesthesia in Iraq, Ethiopia, Yemen, Germany, Denmark, Sweden, USA, Austria, Switzerland and some African countries.

To date 32 candidates have completed the requirements for and have received a certificate of satisfactory completion from the Vhai. These are the students who have satisfactorily completed the programme in batches I through V. In batches VI through X there are presently 30 candidates studying in institutions in north and south India. For the first year of supervised practice, there are currently seven hospitals taking students. As the first year students complete this time and move on to their sponsoring bodies, the next batch of first year students moves up into the institution for supervised instruction.

A record of the amount of anesthesia service rendered by candidates in the course is quite commendable. There are many other factors which could be mentioned in future studies. But in actual numbers of anesthetics performed, we can count from our records in batch I through V, each spending two years, a total of 49,350 anesthetics administered. In counting the first year anesthetics of batch VI, completed in January-February of 1980, we can add another 6,587 cases to this number. This brings a total of 55,937 anesthetic performed by those students in the practice programme to that date.

Of the 32 certificate holders, one certificate holder is not presently in the field of anesthesia. While no nurse would have reason to give an anesthetic without the presence of a doctor, we can look at the distribution of present certificate holders (31) in relation to in-charge of the department.

Number of certificate holders (Vhai) in an institution where there is an MBBS DA or MDDA in charge....	6
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Number of certificate holders (Vhai) in an institution where there is surgeon in charge...	25
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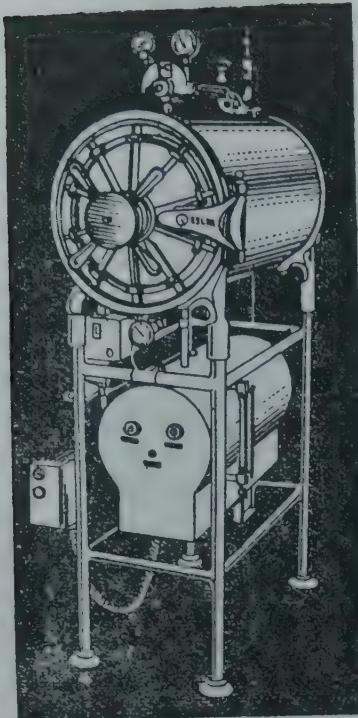
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The following is the distribution state-wise of certificate holders (31) presently at work :

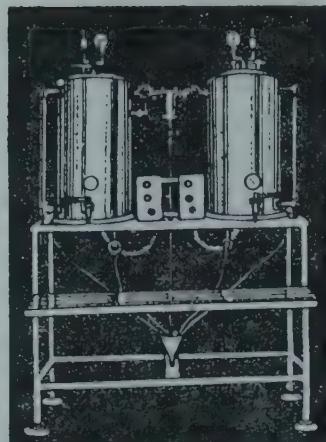
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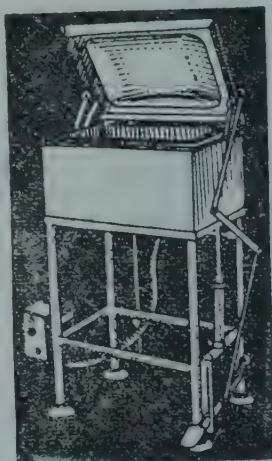
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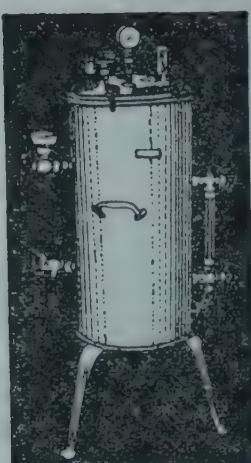
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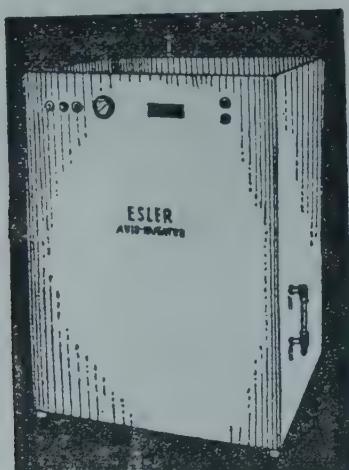
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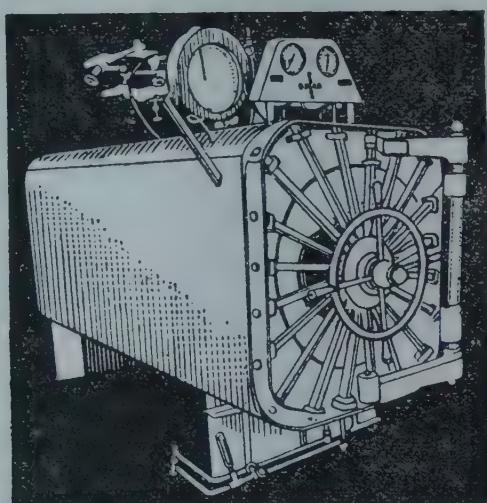
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Thirty nurses are still working in the programme towards certificate. Of these total 62 nurses, 44 are women and 8 are men. To date all the candidates have been from Christian institutions of the Voluntary Hospital sector. Other hospitals of the Voluntary Sector have been contacted and are welcome to send candidates but none have applied. One candidate from West Bengal Government had applied and was accepted but withdrew before the course began for personal reasons.

The following is suggested as a model job description for nurses functioning in a hospital with anesthesia administration responsibilities. Kindly note that this job description is being written AFTER THE FACT THAT NURSES ARE PERFORMING THESE DUTIES SATISFACTORILY and NOT in anticipation of something that might be :-

1. Preoperative visit :

- a. Perform a preanesthetic assessment of the patient and read carefully the medical history and laboratory findings. Identify patient for surgical procedure and be able to establish a personal rapport with the patient before arrival to operation theatre.
- b. Consult with department in-charge about the type of anesthetic used and technique to be utilized. The pre-operative medication should also be scrutinized.

2. Perform the anesthesia procedure as decided upon :

- a. Be able to handle the anesthesia procedure involved in the administration of the anesthetic as previously listed in course objectives.
- b. Maintain adequate anesthesia records. Note vital signs and record every 5 to 10 minutes. Move patient to recovery area only when vital signs are stable.

3. Assist with the maintenance of the anesthesia equipment in the department.

4. Make postoperative visits to the patients until

discharge. Report all complications to department in-charge.

5. Auxiliary services related to anesthesia.

- a. Assist in care of patient in intensive care unit; esp., relating to respiration and after vital signs.
- b. Help in obstetrical dept. with anesthesia and resuscitation of new born infant.
- c. Care of unconscious patient's airway other than anesthesia cases.

We should like to note here that a roll call organization has been formed of nurses in India who are interested in anesthesia of giving anesthesia in any manner. This includes persons other than those entering the present training programme. It also includes some national nurses trained in anesthesia in USA who are supervising students presently in the course of study discussed in this article.

The name of our roll call organization is AINA which is an acronym for Association of Indian Nurses in Anesthesia. A bimonthly mimeographed bulletin is sent out to all AINA subscribers. This contains articles written by and for nurses in anesthesia. It is now in its fifth year and a number of persons have been consistent five-year subscribers.

Also among the subscribers are hospital medical superintendents and administrators who would like to know more about anesthesia. Anyone interested in further information about this may write to : Voluntary Health Association of India, C-14, Community Centre, SDA, New Delhi 110016.

Conclusion :

The programme would expand if standards of training could be approved by Government of India. Since the programme has been shown to be a success, we can hope that this plan may be made more available to be used in a way that will bring optimum advantages to the health care system which is having to cope with ever more financial problems and a population explosion which is daily placing more persons below the poverty line.



*Do not use antibiotics for infections; the body can
fight successfully by itself. Save them for when
they are needed.*

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GOA

Picturesque Goa nestles in a wonderful natural surrounding on the West Coast of India.

One of the ancient gateways of India, it has a long and chequered history.

The recorded history of Goa dates back to the period of the Great Mauryan emperors of India, in the third century before the Christian era. There is some evidence that Goa was an important entrepot even in the first two millenia before Christ and had attracted the Egyptians and Phoenicians.

Later on, between the fourth and the sixth centuries AD, Goa came under the rule of Bhojas and the Mauryas. Among the other dynasties which ruled Goa were the Kadambas, the Mauryas and Vijayanagar. It was also for some time under the sovereignty of Chalukyas and Rashtrakutas.

The word Goa appears to be derived from *Gomanta*, one of the seven divisions of Parashurama Kshetra. The name Gomanta is found in the Bhishmaparva of the *Mahabharata*, the *Harivansha*, the *Skanda* and other *Puranas*.

Goa is a melting-pot of all cultures that blow about freely and harmoniously within its geographical limits. The interplay of cultures from across the Sayadri mountains in the East and from across the Arabian Sea in the West has made Goa a happy blend of the East and the West.

Though there were signs of Christianity in Goa even before the arrival of the Portuguese, it's true Catholic history began with the arrival of the Portuguese in 1498. The Viceroy Albuquerque chose Goa in 1510 for his forays in the rest of India and East. So cosmopolitan and rich Goa was the centre and political and religious capital of the new Empire of the East.

The evangelisation of its people started immediately due to the zeal and hard work of Franciscans, Dominicans and Agustinians. And in the Consistory of January 31, 1533 Clement VII detached Goa from the diocese of Funchal and constituted the diocese of Goa with jurisdiction all over the East, from Cape of Good Hope to China and Japan.

However due to the untimely death of the Pope the bull *Aequum reputamus* was promulgated only the next year by Paul III.

In 1542 landed in Goa one of the outstanding missionaries, St. Francis Xavier with his fellow jesuits. His Sacred Relics are still kept in Old Goa at the Basilica of Bom Jesus and are exposed to public veneration every ten years.

Goa was made a Metropolitan See in 1557 by bull "Etsi Sancta." And Leo XIII conferred on the Archbishop "pro tempore" of Goa the title of Patriarch of the East Indies.

For centuries Goa was a centre of intense cultural and missionary activities. From its shores went far and wide thousands of missionaries fired with the zeal of glory of God and of the salvation of souls. Its local clergy is still spread in all the continents.

Goa's outstanding missionary who keep high and steady the torch of faith in Ceylon is Fr. Joseph Vaz of world fame. The Major Seminary of Rachol played an important role in the christianisation of many parts of Asia and Africa.

In the course of its history Goa had as suffragans the dioceses of Cochin, Malaca, Funai in Japan, Cranganore, Mylapore, Macau, Pequin, Nankin, Mocambique, Daman.

In 1976 the dioceses of Macau and Dili (Timor) were delinked from Goa. Thus the Archdioces of Goa and Daman, names so after the suppression of the diocese of Daman in 1928, ceased to be Metropolitan and was placed under the Sacred Congregation for the Evangelisation of the Peoples.

From the very beginning of the evangelisation of Goa many educational and charitable institutions sprouted everywhere. Famous among the former are the so called parochial schools and among the latter hospitals maintained by the institutions of piety and charity called in Portuguese "Misericordias."

Carmo da Silva

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NOVEMBER 28 - DECEMBER 1, 1980

Pastoral Institute, Old Goa

THEME : RIGHT TO HEALTH

PROGRAMME

FRIDAY, Nov. 28, 1980

9.30 a.m. onwards	: Registration—Pastoral Institute, Old Goa
1.00 p.m.	: Lunch (Registration continues after lunch)
3.30 p.m.	: Concelebrated Holy Mass—St. Cajetan's Church, Old Goa <i>Chief Celebrant</i> Most Rev. Raul N Gonsalves, Archbishop of Goa & Daman and Patriarch of the East Indies.
4.30 p.m.	: Tea
5.00 p.m.	: INAUGURAL SESSION <i>Chairman:</i> Shri Pratap Singh Rane, Chief Minister of Goa, Daman and Diu. <i>Chief Guest:</i> His Excellency Partap Singh Gill, Lt. Governor of Goa, Daman and Diu.
5.05 p.m.	: Prayer Song : Mater Dei Institute, Old Goa.
5.10 p.m.	: Welcome : Most Rev. Raul N Gonsalves, Archbishop of Goa & Daman and Patriarch of the East Indies. Fr. Mathew Chakkalakal, President, CHAI
5.25 p.m.	: Chairman's Address and Releasing of the Convention Souvenir.
5.40 p.m.	: Presentation of the theme : RIGHT TO HEALTH Fr. John Vattamattom, SVD, Executive Director, CHAI
5.50 p.m.	: Inaugural Address : Chief Guest

6.00 p.m. : **Keynote address : RIGHT TO HEALTH**
 Dr. Jecinto Dos Milages Estibeiro, Director
 of Health Services, Govt. of Goa, Daman
 and Diu.

6.30 p.m. : **Speech :**
 Shri Sheik Hassan Haroon, Govt. of Goa,
 Daman and Diu.

6.50 p.m. : **Vote of thanks**

7.00 p.m. : **Opening of the Exhibition—**
Health Minister

7.30 p.m. : **Buffet Dinner (for all registered delegates
 & invitees)**

SATURDAY, Nov. 29, 1980

7.00 a.m. : **Holy Mass (St. Cajetan's Church, Old Goa)**

8.00 a.m. : **Breakfast**

9.00 a.m. : **1st SESSION :**
*Chairman: Fr. James S Tong s.j., Executive
 Director, VHAI*
**Talk: RIGHT TO HEALTH-THE ROLE OF
 THE CHURCH**
 —By Most. Rev. Simon Pimenta, Archbishop
 of Bombay

10.30 a.m. : **Coffee break**

11.00 a.m. : **2nd SESSION**
*Chairman : Dr. (Mrs) Amruthraj Prof. of
 Pharmacology, Bangalore Medical College,
 Bangalore.*
**Talk: RIGHT TO HEALTH AND PEOPLE'S
 PARTICIPATION IN HEALTH CARE**
 —by Dr. Prem C John
 Deenabandhu Medical Mission R.K. Pet,
 Tamil Nadu.

12.30 p.m. : **Lunch (after lunch visit to exhibition)**

2.30 p.m. : **3rd SESSION**
*Chairman : Sr. (Dr) Lillian, Vimala Dermato-
 logical Centre, Versova, Bombay*
**Talk : INTER PERSONAL RELATIONS
 AND COMMUNICATION IN HEALTH
 CARE SERVICE**
 —by Mr. John Lobo
 Holy Spirit Hospital, Bombay

4.00 p.m. : **Tea**

4.30 p.m.	: 4th SESSION
	<i>Chairman : Sr. (Dr) Emmanuel, St. Martin De Pores Hospital Bilaspur, U.P.</i>
	Talk: HEALTH AS A HUMAN RIGHT
	—by Mr. J S Bali, IAS (Rtd) formerly Deputy Secretary, Ministry of Health, Govt. of India
6.00 p.m.	: Free time for visit to exhibition
7.30 p.m.	: Supper
8.30 p.m.	: Cultural programme
	by Mater Dei Institute, Old Goa.

SUNDAY, Nov. 30, 1980

7.00 a.m.	: Holy Mass (St.Cajetan's Church, Old Goa)
8.00 a.m.	: Breakfast
9.00 a.m.	: Group Discussion (Groups, topics for discussion, resource persons etc. will be given at the convention)
12.30 a.m.	: Lunch (after lunch visit to exhibition)
2.30 p.m.	: Panel discussion : How people can plan and implement their own health programme ? — Sr. Sara Kaithathara & her team
4.00 p.m.	: Tea
4.30 p.m.	: Plenary session <i>Chairman: Dr. C.M. Francis, Dean, St.John's Medical College, Bangalore.</i> Presentation of the group report— Final resolutions. (after the session free time)
7.30 p.m.	: Supper
8.30 p.m.	: Cultural Programme by Fontainhas troupe, Panjim

MONDAY, Dec. 1st 1980

7.00 a.m.	: Holy Mass (St.Cajetan's Church, Old Goa)
8.00 a.m.	: Breakfast
9.00 a.m.	: GENERAL BODY MEETING
	<i>Chairman: Fr.Mathew Chakkalakal, President, CHAI</i>
	Introduction : Chairman
9.05 a.m.	: Report of the General Body Meeting of CHAI, 1979 —Sr. Sara Kaithathara, Secretary, CHAI

9.15 a.m.	: Annual report: by Fr. John Vattamattom SVD Executive Director, CHAI
9.25 a.m.	: Report of RPD by Fr. J.A. Menezes s.j.
9.35 a.m.	: Report of CPS by Mr C.T. Thomas
9.45 a.m.	: Report of the Treasurer by Fr. P.Remigius, Treasurer, CHAI a. Presentation and approval of the statement of accounts for the year ended 31.12.1979 b. Presentation and approval of the budget for 1981.
10.00 a.m.	: Presentation and approval of resolutions by Chairman
10.15 a.m.	: Coffee break
10.30 a.m.	: Election of office bearers
12.00 noon	: Vote of thanks
12.30 p.m.	: Lunch
2.p.m.	: Sight seeing tour for those who wish
9.p.m.	: Supper

N.B. : 1. All meals (against coupons) tea, and coffee will be served at the convention site.
2. All announcements will be made by Sr. K. Sara.

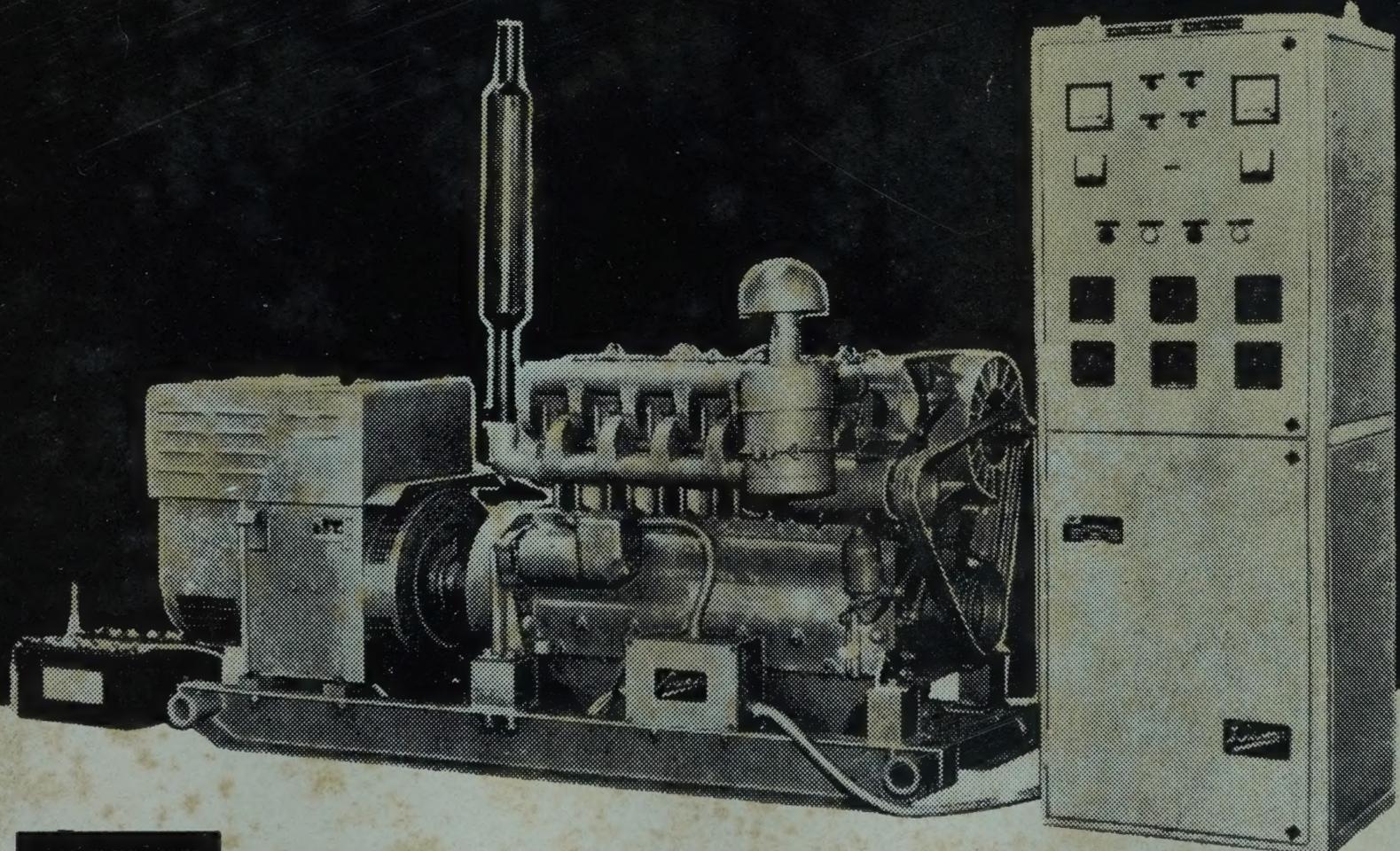
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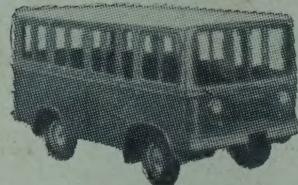
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